THE ATTRIBUTES OF NURSE RESIDENCY PROGRAMS INFLUENCING THE NEWLY LICENSED REGISTERED NURSE

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Submitted to the faculty of the University Graduate School
in partial fulfillment of the requirements
for the degree
Doctor of Philosophy
in the School of Nursing,
Indiana University

December 2020

Accepted by the Graduate Faculty of Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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DEDICATION

I dedicate this work to my three daughters Claire, Norah, and Evelyn. The last three years have been an arduous journey. Your sweet hugs, encouraging notes, and understanding when I was forced to divide my time between you and my work got me to this day. Your patience and grace kept me going even when it felt like I would never be done. I knew you were watching my every move, and because of that, I never gave up. No unforeseen circumstance, a cross country move, or pandemic would stand in the way of completing this for you. Raising three daughters is my greatest treasure in life but being an example of strength and perseverance is my forever gift to you in completing this dissertation.

I dedicate this work to those in my life who have believed in me since I was born. My Mom and Grandma who affirmed that having a college education would be an asset to my life. My best girlfriends who have cheered me on and encouraged me with each milestone. The nurses and colleagues I have worked with over the last twenty years who have blessed me with their knowledge, compassion, and love. And, my Ph.D. cohort at Indiana University and the Robert Wood Johnson Foundation Future of Nursing Scholars who believed in me and I in them as we navigated and bonded through this process, encouraging each other to the end. I could not have done this without the impact that each of these people has made along the way.

I dedicate this to the new nurses and nursing students I have taught over the years. I do this work because you have taught me that the greatest joy of being a nurse comes from the relationships we have with each other and our patients. I will continue this work

towards strengthening the nursing workforce, especially for the nurses who have risked and lost their lives caring for patients during the Covid-19 pandemic.

Finally, I dedicate this work to my best friend and husband, Jeremy, who has walked hand and hand with me from an Associate degree to a Doctoral degree and every day in between. You believed in me even when I didn't believe in myself, and your support in making my dreams a reality has been unwavering. Thank you for loving me.

ACKNOWLEDGEMENT

I want to acknowledge the people who have made this work a reality over the last three years. First, the faculty and staff at Indiana University School of Nursing who saw my potential as a nurse researcher. Specifically, Dr. Susan Hendricks, who believed in the importance of my research topic from the very beginning and guided me in the first year. Dr. Julie Otte, committee chair whose guidance and support stretched me out of my comfort zone, moving me to a new understanding of who I was as a researcher. Dr. Draucker, methods expert whose knowledge, expertise, and dedication facilitated my growth as she worked diligently with me through mounds of data as we sought to "see the forest through the trees." Dr. DeMeester and Dr. Hoffman-Longtin, subject matter experts, expanded my theoretical and conceptual understanding as a researcher and believed in my work. Finally, Dr. Sharron Crowder, health policy mentor whose passion inspired a zest for health policy in me and guided my understanding of the relevance of my research in advocacy and policy.

I want to acknowledge the funding support that I received through Indiana University School of Nursing and the Robert Wood Johnson Foundation Future of Nursing Scholars program. Being able to complete a Ph.D. in three years fully funded was invaluable to a successful completion of this degree. To those that selected me to represent Indiana University as an RWJ fellow based on my work and the impact I would bring to the profession of nursing, I'm so grateful. Finally, the impact that Robert Wood Johnson Foundation Future of Nursing Scholars program staff and mentors made over the last three years through an exciting journey of advancement in leadership, scholarship, and professional development was invaluable. Thank you to my mentor Dr. Susan

Hassmiller who believed in my work and inspired me through her leadership and advocacy for the profession of nursing.

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New nurses report feeling unprepared, incompetent, and highly stressed, contributing to first-year turnover rates of 25% in some healthcare organizations. Turnover, combined with a preparation-practice gap, has alerted advocacy organizations and researchers to recommend the development of nurse residency programs.

Nurse residency programs are a post-graduate training period where new nurses receive enhanced clinical education in the healthcare setting. While highly variable in structure and attributes, programs usually include educational sessions, clinical immersion, and role socialization opportunities. Evidence supports that new nurses participating in nurse residency programs experience positive outcomes, including increased confidence, competence, and decreased turnover rates. Despite this, only half of the hospitals nationwide have implemented a program with most designed around a single health system mission. This dissertation study aimed to identify the attributes of nurse residency programs influencing the newly licensed registered nurse.

An integrative review of the literature and evolutionary concept analysis was completed to examine the state of the science of nurse residency programs. Findings revealed a lack of conceptual and theoretical design and variability among program structures, creating a gap in the literature about the attributes of programs that are most influencing new nurses.

Based on the literature's noted gaps, a qualitative description study was conducted. Purposive sampling strategies were used to recruit nurses who recently

completed varied program models across the United States. New nurses reported the attributes of programs and described how those positively and negatively influenced the transition to practice experience. The overarching themes revealed that new nurses need a cadre of highly supportive individuals across the clinical and educational continuum who espouse astute interpersonal and communication skills. New nurses desire engaging activities with intra and interprofessional team members for clinical skill application, knowledge advancement, and role socialization. New nurses need the structure of meetings at times and in a sequence conducive to learning; and for preceptorship experiences to be facilitated by trained preceptors, on a unit, and of a length that supports confidence for autonomous practice. Future research will include the development and testing of an evaluation tool based on the findings from this study.

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LIST OF ABBREVIATIONS

American Association of Colleges of Nursing	AACN
Evidence Based Model	EBM
Facility Based Model	FBM
Magnet Designation Model	MDM
Nurse Residency Program	NRP
Newly Licensed Registered Nurse	NRLN
University HealthSystem Consortium	UHC
Nurse Residency Program(s)	NRPs
Institute of Medicine	IOM
Cumulative Index to Nursing and Allied Health Literature	CINAHL
Accreditation Council of Graduate Medical Education	ACGME
Evidence Based Practice	EBP
New Graduate Nurse Residency	NGNR
American Nurses Credentialing Center	ANCC
Work Environment Needs Improvement	WENI
Very Healthy Work Environment	VHWE
Healthy Work Environment	HWE
Wisconsin Nurse Residency Program	WNRP
National Council State Board of Nursing	NCSBN
Commission on Collegiate Nursing Education	CCNE
American Nurses Credentialing Center	ANCC

CHAPTER 1

Introduction

Newly licensed registered nurses (NLRNs) continue to assert feeling overwhelmed and unprepared entering the nursing workforce.[1] There is evidence that NLRNs report high levels of stress in the first year of practice due to feelings of inadequacy,[2] incompetence, and lack of confidence[3] in today's technologically advanced and complex healthcare system. Researchers have attempted to identify the reasons for and unintended consequences of these feelings to understand the impact on the nurse and healthcare system.

A gap exists between what is taught in nursing education and what is expected of NLRNs entering clinical practice.[4-6] Known as the preparation-practice gap, contributes to high levels of stress and anxiety in nurses resulting in negative consequences for the healthcare system. The preparation-practice gap impacts NLRNs in areas such as interpersonal and interprofessional experiences and communication, skill proficiency, knowledge for specialized practice, and the demand for increased patient care responsibilities.[4-6]

The preparation-practice gap negatively impacts the individual nurse. The impact is problematic as NLRNs report confusion, doubt, disorientation, and dissatisfaction in the first year of nursing practice.[2] Kramer (1974) identified the feelings experienced by NLRNs as reality shock or the stress, moral distress, discouragement, and disillusionment when the reality of what was believed about nursing is not what is experienced during the first year of practice.[2] The concept of reality shock has expanded into the concept of transition shock as the NLRN transitions from the known role of a student to the less

familiar role of practicing professional nurse.[2] Transition shock results in feelings of anxiety, insecurity, inadequacy, and instability causing physical symptoms of stress, exhaustion, overwhelming fear and doubt in NLRNs in the first few months of practice.[2]

The preparation-practice gap negatively impacts the healthcare system because of increased turnover rates in NLRNs.[2] Turnover, defined as nurses leaving or transferring positions for voluntary and involuntary reasons, is estimated to be between 17-25%[7,8] in the first year of practice and contributes to millions of dollars in lost revenue for healthcare organizations.[9] The instability in the workforce that NLRN turnover creates will further reduce the ability to sustain the current healthcare demands from circumstances like an aging population or an unprecedented pandemic.

Over the last twenty years, the dissatisfaction among NLRNs has led to increasing turnover rates causing negative fiscal effects on healthcare organizations. These circumstances have alerted nurse advocacy organizations to identify strategies to mitigate the loss of NLRNs through calls to action for the implementation of nurse residency programs (NRPs).[10,11] Although some initial data has shown a positive impact on the healthcare system, there appears to be less data on how NRPs impact the NLRN. Also, it is unclear how NRPs are systematically implemented in the healthcare system. Therefore, the following dissertation project was completed to understand better the implementation of NRPs and how programs are explicitly impacting the NLRNs transition to practice. Chapter 1 outlines the background of the historical evolution of NRPs and the types of NRPs used within the United States (US). The goal was to gain a greater perspective of the historical evolution of NRPs and outline the types of programs offered today. Chapter 2 presents the state of the science of NRPs through the completion of an evolutionary

concept analysis and integrative review of the literature of NRP outcomes. Subsequently, based on the results of Chapter 2, a qualitative description dissertation project was completed and is presented in Chapters 3-5 to address how the attributes of NRPs are influencing NLRNs from a variety of healthcare systems across the US.

Background

The global healthcare system relies on professional nurses to provide expert care to patients and families in various settings. Because of the aging population in the United States and the increased occurrence of chronic health conditions, the healthcare system relies on more experienced nurses to provide safe and effective care. As the demand grows for more experienced nurses, the Bureau of Labor Statistics estimates exponentially higher growth rates in the profession of nursing over the next decade. Estimates suggest that 210,000 new nurses are needed yearly to meet system demands for care. Vacancy rates in nursing are anticipated to be 12%, which is 7% higher than other professional positions in the US.[12] Contributing to the nursing profession's vacancies is the high turnover rate of new nurses. Nursing turnover, combined with the 70,000 experienced nurses expected to retire yearly between now and 2030, equates to the loss of over one million nurses in the health care system.[13] Without adequate staffing of nurses throughout the healthcare system, proper care for an aging population, and patients with chronic health conditions will not be sustainable over time in the US.

Evolution of Nurse Residency Programs

The term NRP was minimally used before the year 2000. In early 2000, researchers and nursing advocacy organizations noted a gap between the expectations of NLRNs entering professional practice and their academic preparedness. The preparation-practice gap widened because of the technological advances and the complexity of patient care needs in the healthcare system. In 2003, The Joint Commission published *Health Care at the Crossroads*, identifying the need for healthcare systems to "Create a Culture of Retention" with one strategy being the development of post-graduate training programs for nurses to address the transition to practice challenges NLRNs face. The Joint Commission asserted that the mass retirement of baby boomers further complicated the challenges the nursing workforce faced creating what authors termed a prescription for danger if left unaddressed by healthcare organizations.[10]

In 2009, a landmark national nursing education study through the Carnegie Foundation for the Advancement of Teaching identified a gap between nursing academia and clinical practice causing NLRNs to experience feelings of incompetence and lack of preparedness when entering practice.[4] Therefore, one of the recommendations from the study was the implementation of a one-year post-graduate residency to support the transition to practice of NLRNs.[4]

Finally, in 2010 the Affordable Care Act was enacted into law supporting a landmark initiative by the Institute of Medicine (IOM), and Robert Wood Johnson Foundation titled *The Future of Nursing, Leading Change Advancing Health* to address the nursing profession's needs. The steering committee sought to make recommendations on the type of roles nurses assume to focus on the growing demand for high quality, safe,

and effective health care services for thirty-two million more Americans requiring healthcare.[11] Based on the increasing rates of turnover in NLRNs in the first year of practice and the fiscal impact turnover had on healthcare systems, recommendation number three was implementation of NRPs to enhance the transition to practice experience for NLRNs.[11]

Evidence-based recommendations for enhanced transition support emerged when researchers examined the stressors that NLRNs experience in the first year of practice. Evidence supports that it takes NLRNs twelve months to gain confidence in performing nursing procedures, prioritizing care, organization, and communication.[3] Also, the preceptorship experience impacts job satisfaction and role socialization in new nurses.[3] Thus, based on these outcomes' researchers proposed that NLRNs complete a graduate nurse residency program to improve their confidence during the first year of practice. They also recommended that the academic and clinical practice settings establish collaborative partnerships to facilitate the transition to practice experience.[3]

Research on the NLRNs transition shock led to the recommendation for a 12-month enhanced transition to practice program including the following attributes: to be completed in an established setting to advance knowledge, communication, lifestyle adjustment, change, conflict management, skills, professional roles, responsibilities and mentoring by experienced colleagues and peer to peer collaboration.[2] Thus, researchers and advocacy organizations like The Joint Commission in 2002, The Carnegie study on nursing education in 2009, and the Institute of Medicine Future of Nursing Leading Change Advancing Health report in 2011 called for the development of nurse residency

programs (NRPs) to help bridge the gap between nursing education and clinical practice.[4,10,11]

NRPs, broadly defined, is a focused period in which new nurses enhance their knowledge and skills through role socialization to ensure safe, competent, and autonomous practice.[11] Initial implementation data of NRPs reported increased confidence, competence, and improvement in first-year retention rates of NLRNs.[14-16] Yet despite the strong recommendation for healthcare systems to implement these NRPs and evidence-based support, a study done in 2011 revealed that only (n=219; 37%) of hospitals surveyed in the midwest, northeast, and south reported having an NRP. Results also indicated that the majority of the NRPs were optional, institutionally designed, and internally funded.[17] The results from another study on NRPs reported the components of NRPs from 198 health systems. The results indicated that (n=95; 48%) reported having an NRP. Of these 95 healthcare settings (n=21; 22%) used what the author described as an evidence-based model developed by the University Heathsystem Consortium/American Association of Colleges of nursing (UHC/AACN, known today as Vizient/AACN). The other settings used what the author described as a facility-based model or individual health system/mission focused model (n=51; 54%) or used another model (i.e., state, regional, or unspecified model) (n=23; 24%).[18] Conclusions from this study indicated that significant differences existed among NRP models, and the need for a common operational definition and standardized modules was necessary.[18] It remains unclear why there is a lag in the implementations of NRPs in the US and a lack of consistency on nationally accepted standards for implementing and funding such

programs. When examining the landscape of current NRP models, there are several evolutions of NRPs confusing these various models' utility.

Conclusion

Although NRPs addressed the need for programmatic education for preparation-practice gaps, the systemic implementation and consistency in programs need further investigation to understand why more healthcare systems are not fully implementing them. To address these needs, Chapter 2 presents the integrative literature review and evolutionary concept analysis to address the state of the science through an in-depth examination of NRP literature up until 2019.

CHAPTER 2

The following chapter presents two projects outlining the state of the science of nurse residency programs (NRPs). First, an integrative review of the literature examines ten years of qualitative and quantitative science on NRP attributes and outcomes. Second, using the evolutionary concept analysis method, the theoretical underpinnings of NRPs in the United States (US) were examined, and an NRP exemplar is presented. The author compares the data from both projects to residency models in other healthcare disciplines when possible to better understand how NRPs compare to those other programs. The conclusion of both the integrative review and concept analysis reports the current gaps in knowledge and rationale for the completed dissertation study.

Integrative Review of the Literature

The implementation of NRPs has evolved over the last ten years since calls to action for enhanced transition support for all NLRNs. Yet, evidence suggests that less than half of healthcare organizations have implemented an NRP despite the positive outcomes reported in the literature.[18]

An integrative review was completed to understand the research literature of NRPs since the 2010 Institute of Medicine report recommendation for implementation of programs in the US.[19] The question driving the integrative review was: what are the common components of NRPs and associated outcomes for NLRNs and healthcare organizations reported in the literature in the United States since 2010? The conclusion addresses gaps in the literature and provides a basis for the subsequent project that included an evolutionary concept analysis.

Purpose and Objectives

1. What are the types of nurse residency program models included in the literature since 2010?
2. What are the program components (program length, mentorship model, preceptorship model, type of class structure), reported evidence outcomes (evidence), and retention outcomes (retention) of the NRP by model type since 2010?
3. What are the gaps in the current literature regarding NRPs, and are there research opportunities to further support implementation into the healthcare system?

Methods

The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, PsychInfo, and PubMed were used to search for articles using keywords *nurse residency program, transition to practice program, outcomes, benefits, effects, new nurse, new graduate nurse, and new registered nurse*. The inclusion criteria for articles in the review:

1. nurse residency or transition to practice program
2. in the United States
3. published between 2010 to 2019
4. published in English
5. newly licensed registered nurses (associates or bachelors) in the first and or second year of practice

The exclusion criteria for articles in the review:

1. focused on the quality improvement process for NRP without research

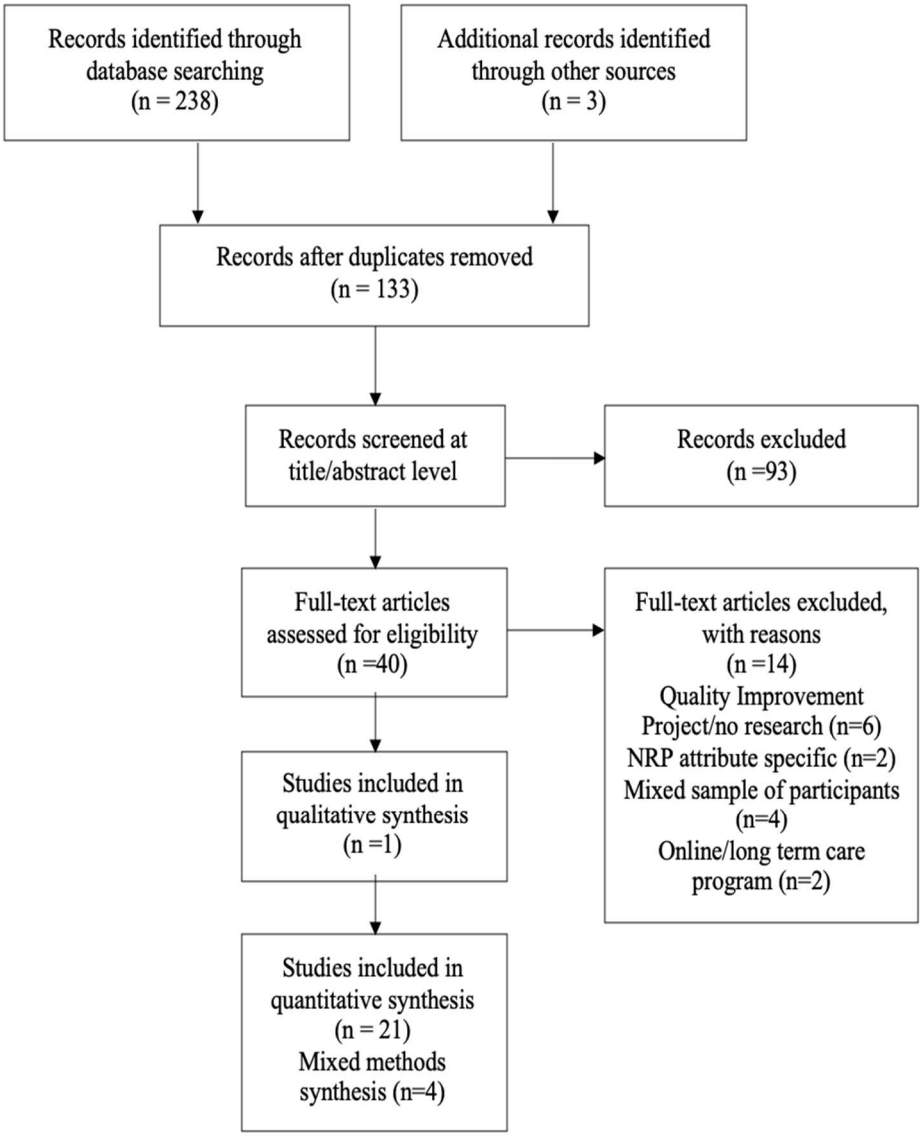
2. focused on another level of nurse, i.e., an experienced nurse, licensed vocational nurse, or nurse practitioner
3. focused on single components of an NRP (i.e., preceptorship, simulation only)
4. online only programs

For this integrative review, the search focused on the evolution of US-based NRP model structures, attributes, and outcomes since 2010. The review focused on the program structures and outcomes of the three common models:[18] 1) facility-based models (FBM) 2) evidence-based models (EBM) such as Versant New Graduate Nurse Residency (NGNR) and Vizient/American Association of Colleges of Nursing (formerly University HealthSystem Consortium UHC/AACN), and 3) other types of models like state coalitions. Additionally, including programs without regard to the NLRN's educational preparation (associate or bachelor's degree) or medical specialty allowed for an overview of program structures and outcomes among program types.

Results

After applying the inclusion and exclusion criteria above, 238 articles were identified in CINAHL, Medine, PsychInfo, and Pubmed databases. Three additional articles were identified through a manual review of reference lists from already acquired studies. After duplicate articles were removed, 133 article abstracts were reviewed resulting in the 40 articles for a full review. Based on the full review, 26 articles met the inclusion criteria for this project (see Figure 1).

Figure 1: Prisma Diagram



The integrative review process included data synthesized from qualitative, quantitative, and mixed methods studies completed since 2010. Studies were further categorized by NRP model type expanding on the three models identified by Barnett (2014) as Facility Based Model (FBM), Evidence Based Model (EBM), or other state coalitions.[18] Barnett (2014) noted a significant proportion of Magnet designated health

systems had implemented an EBM, and evidence supports excellence in nursing in Magnet designated health systems.[20] Thus for this integrative review, Magnet designation model (MDM) was included as a model for comparison of components and outcomes. Based on these model types, evidence from the review were organized as follows: Category A: Facility Based Models (FBM) (n=11) defined as individual health care organization with mission-driven programs; Category B Magnet Designation Models (MDM) (n=6) defined as NRPs from healthcare organizations with an American Nurses Credentialing Center (ANCC) Magnet Designation for Excellence in Nursing, Category C Evidence-Based Models (EBM) Vizient/AACN or Versant NGNR (n=7), and Category D a state coalition NRP from Wisconsin (n=2).

Three subsections describe the evidence within Category A-D. First, descriptive data is presented on the main components that have been suggested should be included in an NRP. Reported components reviewed were 1) program length, 2) if a mentorship program is listed, 3) if a preceptorship program is listed, and 4) if the program includes didactic sessions. The second subsection is an overall presentation of the evidence or outcomes of the study. Last, the third subsection describes the nurse retention outcomes of the studies.

Category A: Facility Based Model

Data analyzed from the FBM NRPs include eight quantitative studies, two mixed methods studies, and one qualitative study.

Program Components. Of the 11 FBM articles reviewed, six studies listed programs that were twelve months long,[21-26,24] three were between six and eleven months,[27-29] and two studies did not report program length.[30,31] Specific mentoring

components of the program were reported in three of the studies[23,26,28] and a preceptorship experience was included in seven studies.[22-24,26,27,29,30] Didactic sessions were described in ten studies.

Evidence. Measurement of outcomes was in each of the studies in this category. The Casey-Fink Graduate Nurse Experience Survey, a tool used to assess NLRNs about skills/procedure performance, comfort/confidence, job satisfaction, work environment and role transition[3] was used in six studies from FBM NRPs. Several authors reported findings of perceived improvement in competence when communicating with patients, families, and colleagues[21-24,29] while a few reported a lack of communication among nurses, physicians, and other staff members.[23,25,30] Data on FBMs revealed enhanced confidence levels in NLRNs in areas related to patient safety[21-23,29] while one study indicated participants reported a lack of confidence in critical thinking.[30]

A large scale (n=1638) retrospective longitudinal study using the Casey-Fink Graduate Nurse Experience Survey revealed significant findings for NLRNs in the following areas: support, patient safety, communication/leadership, and professional satisfaction for pre and post twelve months of practice.[21] NLRNs reported a decline in support and professional satisfaction over time, similar to smaller-scale studies in this category.[26,29]

The concept of support from preceptors,[27,30] coworkers,[23,26,30,31] and managers[26] was an overarching theme impacting both stress and satisfaction in NLRNs. One author reported lower stress levels in NLRNs,[21] while another reported higher stress levels in second career NLRNs in the first six months of practice and decreasing between six and twelve months.[31] Findings from (n=37) participants in a qualitative study revealed stress

as an overarching theme from lack of confidence in knowledge, fear of errors causing patient harm, feelings of inadequacy, and disinterested and unsupportive preceptors.[30] These findings were similar to other studies in this category.

The studies in Category A included data on individual FBM programs from the US's healthcare system using predominantly small, homogenous, convenience samples. The majority of studies were small-scale, descriptive study designs comparing pre- and post-mean test scores, and non-parametric statistical analysis. Various evaluation measures were used to examine Category A variables including satisfaction, stress, anxiety, leadership, commitment, competency, burnout, self-compassion and presenteeism. The study designs and methods used in the studies in Category A precludes the generalizability of findings. Also, the inconsistency in evaluation measures and variables among studies in Category A warrants further examination of what FBM programs' attributes are influencing outcomes in NLRNs.

Retention. First-year retention rates for FBMs ranged between 74%-95%, with the average being 87%. It should be noted that two of the lowest reported first-year retention rates in the 70% range was from a very small scale, single setting study.[7,24] Second-year retention rates of 85% were reported in one small scale, single site study.[22] Inconsistency in reporting of first and second-year retention rates among the studies from FBMs makes generalizability of findings difficult.

Category B: Magnet Designation Model

Category B includes data analyzed from six studies in healthcare organizations with Magnet designation, including four quantitative and two mixed methods study designs.

Program Components. Of the MDMs, one large multi-site study reported program lengths from three months to 18 months,[32] one study reported a program length of fourteen weeks,[33] and the rest of the studies (n=3) were twelve months.[34-36] Information on mentorship was included in four studies,[32-35] and the preceptorship experience was described in all six studies. Didactic sessions were described in five studies.[32-36]

Evidence. A large scale, multi-site study with a follow up mixed methods study examined the work environments of NRPs within 28 Magnet designated healthcare systems and the impact on NLRNs and retention rates. The work environments were defined as Very Healthy Work Environment (VHWE), Healthy Work Environment (HWE), and Work Environment Needs Improvement (WENI).[32] Results revealed that NLRN retention rates were highest in VHWE and turnover rates in the first six months of practice were higher in WENI. Also, NLRNs working in VHWEs report higher work satisfaction and less reality shock. Thus, authors concluded the initial placement of NLRNs in VHWE supports an excellent transition to practice experience.[32]

Three of the smaller-scale studies from MDM programs in Category B used the Casey-Fink Graduate Nurse Experience Survey to measure perceived competence in NLRNs. Results indicated NLRNs reported increased confidence in feeling prepared for practice and communicating with physicians over time.[35,36] Yet a qualitative study in Category B described outcomes of lack of confidence and competence in NLRNs when communicating with physicians. This finding is similar to studies in Category A.[32] Also, one study in Category B reported a decrease in professional satisfaction scores in NLRNs on the CFGNS,[35] which is similar to findings from Category A.

Satisfaction in NLRNs was measured in a few MDM programs using the McCloskey-Mueller Satisfaction scale and qualitative interviews.[32,35] Results from one study noted satisfaction was highest at the beginning of the NRP but decreased in all categories by six months. Between six and twelve-months, NLRNs reported increased satisfaction in all areas except with supervisors.[35] Similarly, a mixed-method study reported high levels of satisfaction among NLRNs at six and twelve months post-hire and was attributed to communicating and connecting with peers, and enculturation into nursing practice.[36] The outcome of enhanced satisfaction in MDM programs was also supported in the large-scale qualitative study.[32]

The studies included in Category B from MDM programs examined data on satisfaction, experience, and retention in NLRNs and healthcare organizations using repeated-measure, descriptive analysis designs. Like studies in Category A, Category B's generalizability is limited based on a single site, homogenous convenience samples of participants. However, the findings on the impact of work environments on NLRN retention rates from a large longitudinal and qualitative study[32] were supported by smaller-scale studies in Category B.

Retention. The retention rates for MDMs are described as the large-scale healthy work environment study and the other MDMs. As previously discussed, retention data from 5,316 NLRNs in a nationwide sample participating in Magnet-designated NRPs were reported as follows: VHWE one year, 92%, HWE 87%, and WENI 76%. Two-year retention rates reported in VHWE were 91%, HWE 79%, and WENI 71%.[32] The first-year retention rates from the four other smaller scale MDMs reported on average to be

93%.[33-36] Only one study in category B reported second year retention rates of 69% in (n=241) participants from a single healthcare system.[33]

Category C: Evidence-Based Model

Category C included data analyzed from seven studies identified as EBM programs with five studies that focused on Vizient/AACN NRP and two studies focused on the Versant NGNR model. All studies include quantitative study designs.

Program components. Of the EBM models reviewed, both Vizient and Versant reported program lengths of twelve months.[37,38] Description of mentorship program was not included in the Vizient studies but was described in one Versant[16] focused study. Preceptorship experiences were presented in only one Vizient model[39] and one Versant model.[16] Didactic sessions were described in all seven studies.

Evidence. Each of the studies included in Category C used quantitative data analysis methods, with three large national sample sets from over a thousand participants. Vizient/AACN and the Versant NGNR have evolved over twenty years and have evidence-based outcomes for enhanced competence, confidence, and improved retention rates for NLRNs in the first year of practice. Vizient/AACN and Versant NGNR have outcomes data for thousands of NLRNs who have completed NRPs in healthcare organizations nationwide.[14,16]

A large-scale study from the Vizient/AACN (previously UHC/AACN) NRP reported ten years of longitudinal data from NLRNs using the Casey-Fink Graduate Nurse Experience Survey and an NRP evaluation tool.[14] A repeated measure design was used at three-time points to describe the confidence and competence levels of (n=1,016) NLRNs between 2002-2012. Results revealed an increase in confidence, competence,

organization, prioritization, communication, and leadership over time[14] with similar outcomes reported in a smaller-scale study in Category C.[40] Also similar to findings from category B, the author in this study revealed NLRNs participating in EBMs in Magnet-designated healthcare systems reported the highest levels of growth in confidence and competence, organization, prioritization, communication, and leadership.[14,32]

The McCloskey Mueller and Nursing Job Satisfaction scale was used to measure satisfaction among NLRNs participating in EBM programs.[16,39,41] Similar to the findings from Category A and B, NLRNs reported a decline in professional satisfaction scores in the first six months of practice and stabilized over time.[14,40] Satisfaction with coworkers,[41,42] and support by senior staff[42] were among the factors that most often impacted satisfaction levels in NLRNs the first year of practice.

Two large scale studies reported findings from ten years of data from the Versant NGNR about the impact of personal and organizational satisfaction on turnover intent and turnover in NLRNs. Results revealed correlations in data on turnover intent in (n=6,000) NLRNs: 1) higher satisfaction and lower intent to leave; 2) work satisfaction/professional and pay with turnover intent; 3) total nurse satisfaction and enjoyment correlated with turnover intent; 4) group cohesion correlated with work satisfaction; 5) organizational commitment positively correlated with nurse satisfaction and work satisfaction.[16] These findings were further supported in a retrospective correlational secondary data analysis study from a thousand NLRNs in the Versant NGNR. Results indicated that group cohesion, job satisfaction, and structural empowerment among NLRNs significantly impacted organizational commitment and turnover intent.[43]

Retention. The retention rates for the two large scale, longitudinal studies from Vizient/AACN and Versant NGNR EBMs were averaged to be 94% with a range of 92.9% to 94.6%.[14,16] The other EBMs included in this review had an average first-year retention rate of 92.6%.[41-43] Second-year retention rates were reported by two studies examining the Versant NGNR and were between 80.4%-91.7%.[16 43]

Category D: State Coalitions

The final NRP model, State Coalitions, falls into the 'other' category.[18] Several states including, Wisconsin, Oklahoma, Hawaii, Maryland, and Pennsylvania, have initiated statewide NRPs based on recommendations by the 2010 IOM.[44] Of these programs, Pennsylvania, Maryland and Hawaii use the Vizient/AACN EBM previously described. The Wisconsin NRP (WNRP) was described in two articles included in this review. The studies were quantitative designs.

Program Components. The WNRP was one year in length and described in the two articles.[45,46] WNRP reported data regarding the attribute of mentoring[45,46] However no information on the preceptorship portion of the program was provided. The didactic sessions were included and described in both studies on the WNRP.[45 46]

Evidence. The WNRP, established in 2005, was a collaboration between health care organizations and academic institutions including 50 urban and rural hospitals.[45,46] A study done between 2005-2008 examined the perceptions of (n=468) NLRNs about the work environment, professional practice, and the predictors of organizational commitment in NRPs. The following outcomes were reported by NLRNs participating in a one-year NRP: 1) clinical decision making scores were significantly higher at twelve months than six months; 2) job satisfaction was highest at twelve months; 3) enjoyment

declined from baseline to midpoint; 4) job stress scores were significantly lower at twelve months; 5) lower stress was related to being a part of a team, individual competence, clinical knowledge, and nursing judgment; 6) stress from environmental factors (supplies, workspace, staffing, work schedule) increased in the first six months.[45,46]

Findings from this study revealed that NLRNs participating in the WNRP had higher job satisfaction, clinical decision-making ability, quality of nursing performance, organizational commitment, and lower stress at twelve months compared to that at baseline or six months. Organizational commitment scores were not significant between program start and end, but the author reported that urban versus rural healthcare systems influenced NLRN organizational commitment.[45]

Similar to the findings in each of the other NRP categories, findings reported in this study found job satisfaction scores decreased between the start and six months and slowly increased by the end. The authors described a limitation of the WNRP was a lack of understanding of the methodological essentials of the NRP that impacts change over time.[45,46]

Retention. Finally, first-year retention rates for Category D, the WNRP state coalition, was reported on 13 cohorts (n=468) NLRNs to be 81% between 2005-2008. Second-year retention rates were not reported for the WNRP.[46]

Discussion of Integrative Review Findings

Initial evidence supports that NRPs are advantageous both to NLRNs and healthcare organizations. Several large-scale studies support the notion of enhanced confidence, competence, and improved retention rates for NLRNs participating in NRPs.[14-16,32] Improving the retention of NLRNs in the first year of practice saves

healthcare organizations millions of dollars in lost revenue yearly.[47] From the literature reviewed, there is high variability among NRPs across the US. Program components were variable based on the type of model. Variability in NRP length was found among the studies included in this review.

Length of the Program

Evidence-based models more closely aligned with the national recommendation for a 12-month program. The initial literature on NRPs length was varied in terms of knowing how long it takes a NLRN to transition to autonomous practice. Some initial recommendations were that programs need a one-year transition period for all NLRNs,[4] while others assert that the six to twelve-month time period is the most challenging time for NLRNs.[3]

Program Mentoring

The inclusion of mentoring of NLRNs over the first year of practice is well documented in the literature.[3,42,48] Mentoring is the formal or informal process of an experienced nurse providing a supportive and caring relationship to an NLRN and has no defined time frame or content. Mentors typically provide both personal and career guidance.[49] The American Organization of Nurse Executives includes mentoring as an essential component for NLRNs transitioning to the practice setting and is outlined in the *Guiding Principles For the Newly Licensed Registered Nurse's Transition To Practice*.[50] There is a reported impact of mentoring as a promoter for positive role transition.[18] However, for this review, studies inclusion of mentoring was variable.

Preceptorship

Preceptorship is different than mentorship as preceptors are active, assigned facilitators during training that perform a defined role within the program. Preceptors often act in a narrower role and orient the nurse to the current work environment.[49] Preceptorship experiences are well documented to support NLRNs' role by enhancing socialization, enculturation, skill application, and knowledge, and have a positive impact on NLRN's satisfaction and competency development.[3] There is indications that preceptors might continue to provide mentorship after the orientation is completed however this is not the focus or included in the subsequent articles as that is often difficult to capture.

Preceptorship experiences were considered a structural component of many of the NRPs included in this review. There is discrepancy in the literature on the inclusion of the preceptorship experience as a component of the NRP. Some healthcare systems have designed programs separate from the preceptorship or use a predesigned model like Vizient/AACN[37] which offers a standardized curriculum that compliments the health system orientation. For example, one study from Category A on FBMs reported that the NRP was considered a separate curriculum from the clinical orientation in which the preceptorship occurs.[21] This creates challenges in understanding the outcomes reported in the literature about NRPs. The preceptorship experience was described as a component of the NRP in 15 studies in this review.

Didactic Sessions

Finally, the impetus for developing NRPs in many healthcare organizations was to enhance the knowledge, skills, and confidence levels in NLRNs in the first year of

nursing practice. Didactic sessions are dedicated periods of time in which the NLRNs spends in a classroom or skills lab setting gaining knowledge from an educator and is a common attribute of most NRPs. However, based on this review, there is a wide variability on the content included, teaching strategies used, and the structure of didactic sessions in NRPs. The content of the didactic session was not critiqued for this review as it was not the focus.

Evidence

In the studies reviewed, didactic sessions as a component of the NRP were listed or are embedded as a standard component in FBM (n=10),[24,29,31 21-23,25-28] MDM (n=5),[33-36,51] EBM (n=7),[14,16,40,42 41 39 43] and the WNRP.[45,46] The number of hours NLRNs spent in didactic sessions varied among all model types with a range from 48 to 160. The content included in didactic sessions was highly variable with the most common topics including leadership,[25,34,52] communication,[24,28,34] critical thinking,[23,24,27,33] and patient safety.[14,25] The WNRP state coalition offered monthly all-day sessions to enhance knowledge regarding specific patient populations, teamwork, organizational, and professional commitment.[45,46]

Overall, the findings in this integrative review support positive outcomes of improved competence, confidence, and retention rates for NLRNs who participate in each category of NRP model discussed. Because the NRP models reviewed vary by structure, the data presented about the attributes of NRPs is inconsistent and varies by each program. Complicating this variability by the model is the inconsistency in evaluation measures used to understand outcomes in NLRNs and healthcare organizations. The discrepancy in NRPs by model, program attributes, and evaluation measures creates a gap

in what it is about NRPs that ultimately impacts the advantageous outcomes reported in each category of NRP in this review.

A few particular areas identified through this review where gaps remain unclear and warrant further understanding are discussed. First, it was evident through the data analysis in this review that coworkers,[26,30,31,41], peers,[23,35,36] preceptors,[27,30] and leadership/management[26,35] plays a role in satisfaction levels of NLRNs. The gap that remains is how these individuals support directly impact satisfaction levels and the NLRNs transition to practice experience.

More than half of the studies included in this integrative review were from a single setting, using repeated measure descriptive design and reporting outcomes from a small (<200) homogenous sample of NLRNs. Thus, the generalizability of findings is limited.

Retention

One of the outcomes researchers use to support the efficacy of NRPs is the retention of or turnover rates of NLRNs in the first year of practice. Turnover, defined as nurses leaving or transferring positions within the hospital for voluntary and involuntary reasons[7] is estimated to be between 17%[7] and 25%.[8] According to Nursing Solutions Incorporated, the average estimated cost of turnover for a bedside nurse is $52,100 resulting in losses between $4.4-$6.9 million dollars annually in healthcare organizations.[9] For these reasons, retention outcomes are commonly reported as strong evidence supporting the need for NRPs. However, despite these immense economic losses, only 48% of health care organizations have implemented NRPs.[18]

For the reviewed literature, the first-year retention rates reported in the large longitudinal study across various Magnet designated healthcare systems varied considerably depending on the environment such that VHWE was 92% and WENI was 76%.[32] Also, the second year NLRN retention rates reported in MDM, VHWE were higher than the second-year retention rates from the large, national EBM program retention rates of 80%.[16] Thus a gap in the literature warrants further examination about what the attributes are of NRPs in MDMs with VHWE that are contributing to these first and second-year retention rates in NLRNs.

Limitations

The limitations of the integrative review are discussed. First, the articles included in this review were evaluated from a single author perspective, increasing outcome bias. Next, this review was limited in scope to NRPs in the hospital setting; thus, the findings do not apply to those NRPs being developed in other healthcare settings. Finally, the evidence to date consists primarily of small scale, single site descriptive studies limiting inference to specific outcomes.

Summary

There is a lack of large scale studies that support consistent outcomes of NRPs. Although there is more in-depth knowledge of the structure and types of studies since 2010, there are additional conceptual underpinnings that were not fully addressed in the integrative review. In order to fully understand the current literature on NRPs, an additional project was completed to identify a deeper understanding of the conceptual underpinnings of NRPs to establish an exemplar by which to base future research. An

evolutionary concept analysis was completed to better understand the state of the science of this topic.

Evolutionary Concept Analysis

The concept of NRP has been loosely defined over the last ten years. To understand NRPs from the perspective of nursing and other disciplines, and advance the science, conceptual clarification is necessary. The evolutionary concept analysis method was used to examine the concept of NRPs. From a philosophical perspective, the evolutionary method is a cycle through an inductive inquiry and rigorous analysis from a sociocultural, disciplinary, and time perspective as the concept unfolds.[53]

In 2002, The Joint Commission published a white paper and prioritized the need for an enhanced transition to practice for newly licensed registered nurses (NLRNs) based on the profession's future needs.[10] In 2010 *The Future of Nursing, Leading Change Advancing Health,* was published by the Institute of Medicine with recommendation three calling for healthcare organizations to implement NRPs.[11] To date, the literature consists of only broad definitions of NRPs, and there is not a blueprint for the structure or implementation of programs. The lack of conceptual clarity has caused ambiguity about the attributes of NRPs, contributing to inconsistency among programs nationwide. The purpose of this evolutionary concept analysis was to use an integrative approach to defining the concept of NRPs, including the attributes, characteristics, or components in nursing and other allied health residency programs to support the development of an exemplar for future research.

Method

The need to examine NRPs from a conceptual lens is warranted based on gaps in the literature. Conceptual clarification enhances how the concept of NRPs is used, making it more useful for evaluating the strengths and limitations.[53] Conceptual analysis, the first step in clarifying and identifying the strengths and weaknesses of the concept of NRPs, supports future research for evaluation tools and theory development. Finally, the evolutionary method supports the examination of NRPs using a heuristic lens to identify concept attributes that can evolve.[53]

The evolutionary method was used to analyze the concept of NRPs using the following steps: 1) identification of the concept and associated expressions or surrogate terms, 2) selection of an appropriate realm (setting and sample) for data collection, 3) identification of attributes and contextual basis of the concept inclusive of interdisciplinary, sociocultural and temporal variations (antecedents and consequences) surrogate and related terms, 4) analyze data regarding the concept, 5) identify an exemplar of the concept, 6) identify implications, hypotheses, and implications for further concept development.[53] The subsequent section provides an in-depth analysis of the evolutionary method.

To outline a broad perspective of what organizations define as a nurse residency program, Google™ search engine was used to obtain descriptions of NRPs across the US. Search terms included: nurse residency programs, accredited nurse residency programs, transition to practice residency programs, and residency program. CINAHL was used to identify the scientific literature in nursing and what other allied health professions

described as a residency program. The following search terms were used: nurse residency program, transition to practice residency, and residency programs.

Evolutionary Concept Analysis Process

Step 1: Identifying the Concept of Interest. The first step in the evolutionary method: *Identifying the Concept of Interest*, nurse residency program, and the surrogate terms are outlined below as a way to determine the concept and the terminology to guide the analysis.[53]

The concept of *nurse residency program* and the essential program attributes have taken on different meanings over the last twenty years. In early 2000, healthcare complexity evolved through advances in patient care and the shift to the electronic health record.[10] Also, around this time, researchers and nursing advocacy organizations identified a preparation-practice gap in which the preparation that NLRNs received during nursing education was not what was expected of them when entering clinical practice. This gap, the complexities of increasing turnover rates of NLRNs in practice, warranted the need for calls to action for the development of NRPs.[2,4,10]

The Joint Commission first used the term *residency program* in *Health Care at the Crossroads Strategies for Addressing the Evolving Nursing Crisis*. The white paper's goal was to identify nursing issues with the possibility of seriously undermining the delivery of safe, high-quality health care and the overall health of Americans.[10] Recommendation II: *Bolster the Nursing Educational Infrastructure* included the implementation of residencies. The Joint Commission defined a residency as a structured, post-graduate training program focused on nurses similar to medical residencies providing the opportunity for enhanced clinical skills in the clinical settings.[10]

A transition program would ease the transition from nursing school to support improved competence and confidence.[10] The Joint Commission identified three priorities for standardization of NRPs: 1) the need for schools of nursing and health care organization partnerships, 2) an accreditation or certifying body and, 3) stable funding. The Joint Commission identified the development of a new NRP model collaborative between the American Association of Colleges of Nursing (AACN) and University HealthSystem Consortium (UHC), which is described in detail later in the analysis.[10]

In 2009 the Carnegie Foundation for the Advancement in Teaching released a seminal multiyear study, *Educating Nurses: A Call for Radical Transformation.* The primary goal was to determine if nurses entering practice are prepared with the skills and knowledge for practice and prepared to continue learning clinically for the future.[4] Through this work, the authors identified an unsustainable gap between nursing education and the practice setting, causing nurses to feel unprepared for clinical practice demands.[4] The authors recommended the implementation at least a one-year, quality, postgraduate residency in the practice setting.[4]

In 2010, the Institute of Medicine *Future of Nursing, Leading Change Advancing Health* report was published by an independent review panel of nursing and healthcare experts. With the goal of strengthening the nursing workforce, the largest component of the healthcare system, the panel defined Recommendation 3: Implementation of Nurse Residency Programs.[11] Thus, the goal was to emphasize that state boards of nursing, accrediting bodies, the federal government, and health care organizations should take action to support nurses participation in NRPs after they have completed post-licensure or advanced degree programs or when they are transitioning into new clinical practice

areas.[11] The committee outlined these areas to support NRP development: 1) The Secretary of Health and Human Services should redirect all graduate medical education funding from diploma nursing programs to support the implementation of NRPs in rural and critical access areas, 2) Health care organizations, the Health Resources and Services Administration (HRSA) and Centers for Medicaid and Medicare Services, and philanthropic organizations should fund the development and implementation of NRPs across all practice settings, 3) health care organizations that offer NRPs and foundations should evaluate the effectiveness of the program in improving the retention of nurses, expanding competencies, and improving patient outcomes.[11]

From these expansive calls to action, the concept of NRPs and the surrogate terms of post-graduate training programs, post-graduate residencies, and transition-to-practice programs evolved over the last twenty years. Each of these concepts is used in this analysis to examine nurse residency programs.

Step 2: Identifying the Realm. The second step in the evolutionary method: *Identifying the Realm,* supports selecting the setting and data collection sample to explore the concept of NRPs. The setting refers to the time to be examined, and the disciplines or types of literature included for the analysis.[53] This review included the first call to action by The Joint Commission in 2002 to 2018.

While the primary interest for concept development was on nurse residency programs for this analysis, other allied health care residency programs were included to substantiate the concept's final analysis. First, CINAHL was used to search for the concept of NRPs in the scientific literature including these search terms: description of

nurse residency programs or transition to practice programs in the hospital setting with a focus on new graduate nurse or newly licensed registered nurses.

The initial search yielded 236 articles. Following an abstract review of the articles, nineteen met the inclusion criteria. Next, an internet search was completed to identify NRP programs' examples or the descriptions of programs from healthcare organizations across the US. Through the use of popular media to gather data on NRPs, a large amount of information was used to enhance concept development.[53]

To understand the concept of what other allied health professions deem a residency, additional internet and scientific literature searches were performed for medicine, pharmacy, pastoral care, and physical therapy residency programs. Having a broader understanding of a residency from multiple allied health and medical perspectives supports the attributes of NRPs.

Step 3: Data Collection Concept Attributes. The third step of the evolutionary method has two parts. The first step includes identifying the attributes of the concept of a real definition and the grouping or clustering of variables that identify the concept possible. The question that guided the identification of relevant literature was *what are the characteristics of nurse residency programs*?[53]

Step 3: Data Collection Related Terms. The first step to uncovering the attributes of NRPs is identifying related and surrogate terms. Related terms are the concepts that share some relationship to the concept of interest but do not share the same attributes.[53]

The National Council of State Boards of Nursing (NCSBN) Learning Connection Transition to Practice program, an evidence-based online course series for NLRNs and

preceptors, evolved from a study by NCSBN between 2011-2013. The Transition to Practice (TTP) program is a six-month, five-course series of self-study modules on communication and teamwork, patient and family-centered care, evidence-based practice, quality improvement, and informatics with six months of organizational support for NLRNs. The goal of the self-study modules is to challenge new graduates to apply knowledge using compassion, develop skills, and enhance critical thinking as they transition from novice to expert in the profession.[54]

The NCSBN TTP program asserts that preceptors help a successful role transition. Thus, a section of each module includes an interactive section for the NLRN and assigned preceptor to collaborate. Additionally, the NCSBN TTP offers a course specifically developed for preceptors called Helping *New Nurses Transition to Practice.*[54]

The next related term, *preceptorship, or internship*, is defined as a post-graduate orientation program. A preceptor trains an NLRN employed by a healthcare system for three to twelve months in a clinical immersion experience.[55] Internships are considered an accelerated format for transitioning NLRNs into complex roles like intensive care. Internships include a didactic classroom component and a preceptorship experience lasting six weeks. Internship programs in preoperative and medical-surgical areas often include a mentoring component and didactic sessions.[55]

Finally, *buddy programs* are a post orientation support program in which experienced nurses guide and provide feedback to NLRNs once they begin autonomous practice.[55] Each of the related terms discussed, Transition to Practice, internship/preceptorship, and post orientation program share a relationship and support the development of the attributes of NRPs, but alone do not fully encompass the concept.

Step 3: Data Collection Surrogate Terms. Surrogate terms are defined as the terms interchangeably used to express similar concepts[53] and considered a necessary step to ensure the inclusion of all relevant literature.

Many healthcare systems across the US have used alternative terms to describe a residency program. One example *Transition to Practice* or T2P, a twelve-month transition program that all NLRNs complete upon hire to the health system. The T2P program's attributes include a theoretical foundation of Adult Learning Theory, Experiential Learning Theory, and From Novice to Expert Theory, a three-month orientation period followed by the Learning Connection didactic session series. The following content is included in the Learning Connection series: communication, prioritization, managing changing patient conditions, evidence-based practice, interprofessional collaboration, management of patient care, patient-centered care, quality care, the business of healthcare, professional roles, and leadership. The T2P includes a mentoring program and a leadership support structure to enhance NLRN success.[56]

Another surrogate term, Graduate Nurse Internship Program (GNIP), is a twelve-month program developed to enhance new nurses competence and confidence in providing quality patient care and improve retention in the healthcare system.[24] The attributes of the GNIP include: the theoretical model, Watson's Human Caring Theory, classroom instruction, specialty classes, a preceptorship experience, six internship forums, and simulation.[24]

Step 3: Data Collection Identifying the Contextual Basis. Identifying the contextual basis of NRPs allows for application of the concept in situational, temporal,

sociocultural, or disciplinary contexts.[53] The contextual basis for this analysis of NRPs included situational and disciplinary contexts.

One of the first NRPs in the US started at Children's Hospital Los Angeles in 1999 as a one-year pilot project. After a few years of successful outcomes, the Versant New Graduate Nurse Residency (NGNR) was launched nationwide as a business model to gather, evaluate, and share data and information.[38]

The Versant NGNR is defined as a comprehensive education and training system created specifically to enhance the ability of the newly graduated registered nurses to become safe, competent, and professional practitioners. The Versant NGNR attributes include: a theoretical Novice to Expert framework, one year in length, curriculum with classes and case study, structured clinical immersion with a team precepting experience, clinical rotations, mentoring, debriefing, self-care sessions, a residency leadership group, and a competency-based evaluation.[16]

A second well-established NRP, The University HealthSystem Consortium American Association of Colleges of Nursing (UHC/AACN) NRP, known today as Vizient/AACN, was established as a partnership between UHC chief nursing officers and AACN baccalaureate program deans in 2002. The UHC/AACN was established to standardize NRP curriculum across programs in the consortium and to develop a demonstration project for BSN graduates.[57]

The attributes of the Vizient/AACN NRP include: theoretical Novice to Expert Framework, one year in length, four to eight hours of a core curriculum, practice partnership between a university hospital and school of nursing, preceptor trained and guided clinical experience, leadership oversight by a residency coordinator, mentoring

and a post competency evaluation.[57] The core curriculum includes case study analysis and group discussions focusing on leadership, professional roles, quality outcomes, ambulatory care nursing, and evidence-based practice with a final project.[37]

Next, statewide coalition NRPs like the Wisconsin NRP (WNRP) was established over the last twenty years because of nursing workforce issues. The WNRP is a collaboration between academic leaders, health care, and nursing organizations within 50 public and private hospitals in Wisconsin and eastern Minnesota. The attributes of the WNRPs include 15 months in length, a preceptorship experience with preceptor training, monthly educational sessions, and mentoring by clinical coaches.[58]

A large component of the WNRP is the all-day monthly educational sessions guided by clinicians or experts to support critical reflection for NLRNs. The learner-centered sessions focus on capacity building in five areas: self (professional development, stress management, critical thinking), the team (time management, delegation, conflict resolution), practitioner (specialized clinical focus areas), organizations (customer satisfaction, national patient safety goals), and profession (lifelong learning, accomplishments).[58]

Active learning strategies, including problem-based learning and simulation experiences promote critical thinking and decision making in the WNRP. Next, experienced clinical coaches serve as role models and provide NLRNs with guidance, teaching, and mentoring. Finally, the stakeholder buy-in, transparent communication, adequate resource allocation, and on-going data collection are considered the essential elements to the WNRP.[58]

Another common type of NRP in the US, the facility-based model (FBM), is developed based on the mission of the healthcare system (FBM).[18] The literature on FBM programs supports these common attributes: one year in length, a preceptorship experience, didactic class/seminar sessions with case study, and simulation.[23,27,59] The didactic class session includes content on professional role socialization, critical thinking,[23,27,60] and end-of-life care.[23,60] Mentoring is an attribute in a few FBMs[23,35,60] as is a dedicated leadership team for program coordination.[23,25,36] Some of the less common attributes in FBM programs includes a separate hospital and unit orientation experience from the NRP,[36,52] and participation in the program is optional for NLRNs.[23,27] Finally, findings from a 2014 study described the attributes of NRPs in hospitals across the US. The attributes most commonly reported include program lengths between 10 and 52 weeks, an evidence-based project, and a mentoring component.[18]

Another contextual basis for identifying NRP attributes is examining the accreditation standards set forth by two national accrediting bodies. Researchers assert all NRLNs should complete an accredited NRP, yet most programs today are not accredited.[61] To date, there are two national accreditation organizations for NRPs, The Commission on Collegiate Nursing Education (CCNE) and the American Nurses Credentialing Center (ANCC).

The CCNE accredits NRPs that meet the following standards 1) minimum of 12 months long, 2) a collaborative partnership between accredited healthcare organizations and accredited schools of nursing, 3) guided on the premise of professional role socialization through role transition and role integration, and 4) encompass a preceptorship experience. NRPs seeking accreditation must show evidence of these

standards of program delivery, institutional commitment and resources, curriculum and assessment, and achievement of program outcomes.[62]

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) known as the Practice Transition Accreditation Program accredits programs that meet the following standards: 1) designed with the theoretical Novice to Expert framework and conceptual domains including program leadership, 2) quality outcomes, 3) organizational enculturation, 4) development and design, and 5) practice-based learning using preceptors and mentors. Also, programs must be at least six months in length, include organizational orientation, include practice experiences, and supplemental activities to promote professional development.[63]

Finally, identifying the contextual basis of NRPs through an interdisciplinary lens of what other allied health professions like pharmacy, medicine, physical therapy, and pastoral care provides insight for the attributes defining NRPs.

The medical residency which is a postgraduate education program, is a requirement for all physicians following medical school. The attributes of medical residency programs include: 1) bedside teaching, 2) didactic session, 3) clinical skill competency, and 4) professional development under the guidance and support of trained physicians.[64] Professional development and didactic sessions focus on professionalism, communication, leadership, critical thinking, evidence-based practice, and teaching. A strategic component of the medical residency is the role-modeling residents receive by faculty.[64] Finally, the success and improvement of medical residencies depends on the use of program evaluation. Two of the core attributes of medical residencies are funding

by the federal government,[65] and a single, not-for-profit accrediting body known as the Accreditation Council for Graduate Medical Education.[66]

Finally, unlike medical residencies, the pharmacy, physical therapy, and pastoral care residencies are optional post-professional advanced training programs. Each of these programs' attributes includes integration into the profession through clinical and didactic specialized training.

A pharmacy residency, defined by the American College of Clinical Pharmacy, encompasses training in a clinical focus following the completion of a pharmacy degree. The pharmacy residency training is two years in length, with the first year being generalized and second-year specialized training. The American College of Clinical Pharmacy defines the residency as a post-graduate training that allows a resident to perform as a licensed practitioner but also train with an experienced preceptor.[67] The pharmacy residency program is accredited and builds upon the knowledge, skills, and attitudes obtained during pharmacy education. The residency's goal is to enhance skills and competence in the first two years of pharmacy training.[67]

While a residency is not a requirement to begin working as a pharmacist, it is encouraged or often required to be eligible for some specialty roles.[68] The American Society of Health-System Pharmacists, an accrediting body for pharmacy residencies, helps promote a program that builds on the Doctor of Pharmacy education and outcomes to contribute to the growth of clinical pharmacists.[69] The standards for accreditation include: 1) minimum of 12 months long of full-time practice, 2) exemplary learning environment, 3) a licensed pharmacist residency program director, 4) qualified and trained preceptors for supervision in clinical experiences, 5) in an accredited healthcare

system, and 6) program design including patient care, advancing practice, leadership/management, teaching, education, and dissemination of knowledge and program and resident evaluation.[69]

Next, the physical therapy residency is a post graduate training period used to support continuous guidance as new clinicians become competent in the development of clinical reasoning, judgment, and psychomotor skills.[70] Some physical therapy residency programs are accredited by the American Board of Physical Therapy Residency and Fellowship Education, which has seen a significant increase in accredited programs from 2009 to 2014.[70] For example, The University of California San Francisco's post-professional physical therapy residency is accredited by the American Physical Therapy Association. Attributes of the residency include: length between 12-15 months, four to eight hours of didactic courses with active learning strategies, 20-25 hours per week of patient care clinical experiences, interdisciplinary collaboration, mentoring, teaching opportunities, and program evaluation.[71]

Finally, like pharmacy and physical therapy, pastoral care residencies are not a post-graduate requirement, but there are over 300 pastoral care programs in hospital settings that are accredited by The Association for Clinical Pastoral Education. While accreditation is not a requirement of pastoral care residency programs, accreditation is the primary purpose for providing quality assurance in the field of pastoral education.[72] Johns Hopkins offers a one-year, paid, full time, post-graduate experiential clinical pastoral education program focusing on role development as a member of the interdisciplinary team, and professional development including personal and pastoral reflection.[73]

The pharmacy, physical therapy, and pastoral care residencies are not a requirement for practice. The opportunity afforded with additional training supports enhanced competence, leadership, knowledge development, and professionalism for clinical practice.[70,73]

Step 3: Data Collection Identifying the Antecedents. Antecedents are events or incidents that occur or should be in place before the occurrence of the concept[74] and support a foundational understanding of events that must occur for NLRNs and the health care organization before the implementation of an NRP.

The antecedents for the individual NLRN varies by program. An integrative review of the literature described the antecedents of NLRNs starting an NRP, which included the need to be a graduate of a Diploma, Associate, or Baccalaureate nursing program. In contrast, other programs like the Vizient/AACN require the NLRN to have a Baccalaureate degree to be qualified.[44] Another antecedent includes licensure requirements. Some NRPs allow the NLRN to have a temporary practice permit to participate in the program[44] while others require the NLRN to pass the National Council Licensure Exam before starting the program.[75]

One author described program antecedents that varied by the healthcare organization, including the need for senior leadership and stakeholder buy-in, an interprofessional team of nurse managers, preceptors, human resources, financial department, and educators funding and program development.[44]

Finally, an antecedent for each of the allied health professions discussed in this analysis is completing a graduate degree. This antecedent differs from the NRPs discussed in this analysis, which is established for the post associate or baccalaureate-

prepared NLRNs. In this analysis, both nursing and the allied health professions have a post-graduation learning curve to enhance clinical practice experiences and support enhanced socialization for professional practice.

Step 3: Data Collection Identifying the Consequences. Consequences are events or incidents that occur due to the occurrence of the concept or outcome of the concept.[74]

Following an integrative review of the literature from 2017, the author identified the healthcare organization consequences from implementing an NRP included cost savings and increased NLRN retention rates. The NLRN consequences included improved critical thinking and leadership skills.[48] Ten-years of longitudinal data on NLRNs participating in NRPs identified the following consequences: increased competence and confidence levels, improvement in perceptions of the organization and prioritization skills, and enhanced communication and clinical leadership capabilities.[14]

The data collection step of the evolutionary concept analysis outlined the related and surrogate terms and the contextual basis of NRPs including, antecedents, consequences, and attributes of residencies relevant to other allied health professions. This step supports insights into the answer to these research questions about the attributes of NRPs and whether the findings are considered relevant data.[53]

Step 4: Data Analysis. The next step in the evolutionary method, data analysis, allows for the synthesis from the data collection findings using a heuristic and iterative approach to determine the attributes of an NRP. The answer emerged from the data and is discussed in this section.[53]

The evolutionary concept analysis method served as a guide to outlining what the literature supported as the foundational and cohesive attributes of NRPs. The foundational attributes evolved as a temporal perspective as the needs of NLRNs during the early transition to practice phase. The consensus among researchers and healthcare leaders about the preparation-practice gap in NLRNs served as the impetus for the foundational attributes for NRPs, including: 1) an academic-practice partnership, 2) design based on a theoretical framework, 3) stakeholder buy-in and sound leadership support, and 4) national accreditation.

NRPs serve as a post-graduate transition to practice period for NLRNs. The first foundational attribute, establishing an academic-practice partnership, was strongly supported in the literature by researchers, regulatory bodies, and accrediting organizations because of the enhanced support NLRNs need before and after graduation.[10,57,62]

The second foundational attribute, an NRP design based on a theoretical framework, was consistent among several well-established programs. For example, Vizient/AACN and Versant NGNR designed programs using The Novice to Expert model.[16,57,60] Also, to be accredited by the ANCC, the NRP must be designed based on the Novice to Expert Theoretical model.[63]

The third foundational attribute, establishing stakeholder buy-in and having dedicated program leadership support from the academic and healthcare organization, is supported in the literature for NRP success. [23,25,36-38,58,63] Finally, national accreditation of all NRPs is supported in the literature as a means to establish standardization across all NRPs.[10,61-63]

Next, the cohesive attributes evolved from the literature as those characteristics that are consistent among existing NRPs, including 1) program length, 2) preceptorship and trained preceptors, 3) mentoring, 4) didactic teaching sessions with active teaching strategies, 5) common core content, and 6) evaluation measures. Each of the cohesive attributes is discussed below.

First, the length of the NRP being one year was most consistently reported throughout the literature within and outside of nursing.[23,27,37,56,60,62,73] This supports the evidence from the above integrated review. The next cohesive attribute, inclusion of the preceptorship experience identified as an organized, evidence-based and outcome-driven approach to verifying competent practice[16] with the use of trained preceptors to support NLRN growth was well supported throughout this analysis.[15,16,23,27,58,59,62,63,72] The third cohesive attribute, mentoring, was identified as beneficial to providing additional support for NLRNs throughout the first year of practice.[15,23,35,38,58,63] These findings are supported by the integrative review but not always presented in the literature.

The fourth cohesive attribute, didactic teaching sessions support the advancement of knowledge, professional relationship development,[38] critical reflections,[58] and critical thinking.[14,23,27,60] The use of active teaching strategies like case study analysis, simulation, and interprofessional experiences was well supported in the literature [14,23,27,66] Next, common core content emerged throughout this analysis as a recommendation or already existed in NRPs including 1) patient safety,[15] 2) communication,[54,56,66] 3) leadership and 4) evidence-based practice.[37,57,59]

The final cohesive attribute, program evaluation measures, while measures were highly inconsistent in the data reviewed for this analysis, the need to evaluate NRPs was

evident. The 2010 IOM Future of Nursing report recommended that healthcare organizations evaluate effectiveness of NRPs in improving the retention, expanding clinical competencies, and improving patient outcomes[11] Also, NRP evaluation is a standard for accreditation by the CCNE and ANCC.[62,63]

A discrepancy both within nursing and other allied health professions is requiring a post-graduate residency for all novice care providers entering a clinical practice profession. To date, there is no requirement for NLRNs to complete an NRP despite substantial support by nursing researchers and health care advocacy organizations.[4,10,57] Several of the studies reviewed indicated that participation in the NRP was voluntary and not a requirement of hire,[23,27] which is similar in pharmacy, physical therapy, and pastoral care residencies. For those health care organizations that use the Vizient/AACN and Versant NGRN, participation in the NRP is a requirement of hire.[37,38] Since the 1940s, all physicians have been required to complete an accredited medical residency and warrants the need for this to be considered in the nursing profession.[76]

Step 5: Identifying an Exemplar. The next step is identifying an exemplar or practical validation of the concept in a relevant context.[53] None of the NRPs examined for this concept analysis included each of the foundational and cohesive attributes for a practical demonstration of the concept,[53] but combing the attributes of the two evidence-based programs Versant NGNR and Vizient/AACN created an exemplary model:

A nurse residency program is an one year accredited post graduate training program for newly licensed registered nurses. The goal of the NRP is to facilitate and support the NLRNs transition to the clinical practice environment.

The NRP development, goals, and evaluation are supported by stakeholders and leadership's collaboration among the healthcare organization and an academic affiliate. The NRP is theoretically developed and designed with cohesive attributes supporting the enculturation of NLRNs entering the profession. The cohesive attributes include a clinical immersion preceptorship experience with trained preceptors, mentoring with expert nurses, and professional role socialization through didactic sessions using active teaching strategies like case study analysis, simulation, and interdisciplinary experiences. The core content focuses on areas to enhance critical thinking, communication, quality care, and patient safety. Through learner-focused sessions, the NLRN evolves through relationship development, leadership, mentoring support, and critical reflection to gain confidence for autonomous practice.

The exemplar outlined above is not the prototype of NRPs, but rather an example of how the concept might appear in real life to clarify the purpose.[53] Also, existing NPRs can use this exemplar to compare their program attributes against and assist those healthcare organizations seeking to implement an NRP.

Discussion

The need to analyze the concept of NRPs was warranted based on the identified gaps in the literature. Wide variation among NRPs in the US supported the need for establishing foundational and cohesive attributes. Through a heuristic lens and the evolutionary concept analysis method, the foundational and cohesive attributes emerged through the data. Also, the evolutionary method supports the application and evaluation of these attributes over time.[53] The foundational and cohesive attributes can serve as a blueprint for those healthcare organizations that have not implemented a program to date.

This analysis in addition to the integrated review findings lends support as the building blocks to expand the concept of NRPs from a scientific and theoretical perspective over time.[74] The foundational and cohesive attributes that emerged support the development of evaluation measures and a theoretical framework. There is no theoretical framework for NRPs, which has led to inconsistency in programs to date. Therefore, to understand the full potential of NRPs on NLRNs, healthcare systems, and patient outcomes, a unified, accredited, evidence-based and, theoretically driven model is necessary. A theoretical framework can serve as a guide for researchers to develop studies and test hypotheses, further expanding the state of the science of NRPs.

Evidence already supports that NRPs improve NLRN competence, confidence,[16] and the first year of practice retention rates,[14] but what remains unclear is what attributes of NRPs are directly impacting these outcomes.

A final implication for this analysis is the development of policy. In 2018, the American Academy of Nursing recommended all healthcare employers be required to have an accredited NRP that should be funded by Center for Medicaid Graduate Medical Education, outlining six areas of focus for achieving this goal.[77] Yet, based on the literature, it is unclear how many NRPs exist in the US, and of those programs, the design, attributes, evaluation measures, and outcomes remain highly inconsistent. There are several reasons healthcare organizations could be hesitant to prioritize the development and accreditation of NRPs, including financial constraints, a lack of stakeholder and leadership buy-in, and ambiguity about the attributes that support positive outcomes. Thus, nursing policymakers need to pay particular attention to the consistency and requirement of NRPs and resources to garner support.[18] Also, to receive

funding from The Center for Medicare and Medicaid Services, who currently support physicians, pharmacist, and pastoral care residencies, NRPs need to be accredited.[78]

Limitations

The limitations of this evolutionary concept analysis are described in detail. First, this analysis is limited in scope and did not account for the academic preparation level of NLRNs when identifying the foundational and cohesive attributes. There may be variations in the attributes depending on the educational level of the NLRN that were not included in this analysis. Future research is needed to distinguish the needs of associate versus baccalaureate level NLRNs entering practice. The next limitation, the attributes of clinical practice specialties and acute versus ambulatory care NRP attributes were not included in this analysis. Both specialized and ambulatory care settings will require further analysis based on the needs of the NLRNs working in these settings. This concept analysis encompasses a foundational definition for NRPs as a whole.

Summary

The advantageous outcomes of NRPs are well documented throughout the literature. The integrative review of literature and evolutionary concept analysis established foundational and cohesive knowledge and attributes to support the standardization of NRPs across the US. More research is needed to understand what NLRNs believe are the attributes most impacting the outcomes like increased competence, confidence, and improved retention rates reported in the literature seen in existing NRPs. Using the integrative review and evolutionary lens allowed the concept of NRPs to be better understood and clarify the current state of the science of this topic. As

the body of knowledge and research on NRPs expands, so can the concept and attributes of NRPs.

CHAPTER 3

Based on the identified gaps in the integrative review of literature and conceptual analysis in Chapter 2, the following dissertation project was completed to provide new information regarding NRPs. The goal of the study was to gather data that can be used to identify NRP attributes revealed to be important to NLRNs and create better tools of evaluation to determine if essential benchmarks are met to support the ongoing programs.

Purpose

The purpose of this qualitative description study was to identify and describe the attributes associated with NRPs that newly licensed registered nurses (NLRNs) believe influenced their transition to practice. The specific aims for the study were to:

1. Construct a list of common NRP attributes that NLRNs believe influenced their transition to practice.
2. Determine which of these attributes are related to the following components of the NRP: (a) interactions with persons associated with the NRP, (b) activities included in the NRP, and (c) the organizational structure of the NRP.
3. Provide an in-depth description of those attributes that the NLRNs suggest are most influential in their transition to practice.

Method

A qualitative description approach was used for the study. Qualitative description is the method of choice when the aim of a study is a straightforward description of a phenomenon.[79] The method is used to present "the facts of the case in everyday language"[79] (pg. 336). Low-inference interpretation is used to stay close to data, and the analysis focuses on the surface meaning of participants' words.[79] Qualitative description

is an inductive process that employs an emic stance and is conducted in a natural setting.[80] Semi-structured interviews are often used to obtain targeted information about the phenomenon being studied from stakeholders with knowledge about and investment in the phenomenon, and content analysis is typically used to obtain a focused summary of stakeholder narratives.[79]

Naturalistic inquiry provides the philosophical foundation for the qualitative description approach. Naturalistic inquiry consists of five axioms:

1. There are multiple, intangible realities that are studied holistically and each inquiry creates a divergence into more questions;
2. The inquirer and respondent relationship are interrelated through the process of interacting;
3. The goal of inquiry is the development of an idiographic body of knowledge through context-bound working hypotheses;
4. Explanation of actions is interactive, nonmanipulative in natural context resulting in plausible inferences;
5. The inquiry is value bound through inquirer values, value influenced by the paradigm, theory, methods used in data collection and analysis, and the context[81] (pg. 238).

As the primary aim of the study is to provide an in-depth description of NRP attributes that NLRNs view as most influential in their transition to practice, qualitative description is the most applicable method. The study is designed to create a straightforward and comprehensive description of the attributes in a form that will be easily used by persons planning, modifying, and implementing these programs.

Sample

Purposive sampling was used to select specific participants who participated in varying NRP models across the United States. This sampling strategy was used to select participants who provided "information-rich cases"[79] (pg. 338) about their experience in the NRP. A semi-structured interview guide was used to support "moderately structured

open-ended"[79] (pg. 338) questions that allowed for a full expression of the participant.[80] Finally, through content analysis, responses to questions were counted to identify patterns, but still maintained a low inference approach to data analysis. The analysis allowed for a "straight descriptive summary of the data,"[79] which evolved (pg. 338) but stayed very close to the participant's words. The outcomes resulted in a methodologically sound study.

Purposive sampling using a maximum variation strategy was used.[79] The sampling strategy consisted of the recruitment of NLRNs from different geographical locations from health systems with the following NRP types: 1) facility-based models, 2) evidence-based models, i.e., Versant NGNR and or Vizient/AACN and 3) either a facility or evidence-based with Magnet designation. The inclusion criteria for participants included: (1) Bachelors (BSN) or Associate degree(ADN) prepared NLRNs (2) worked in a hospital setting (3) worked in medical or surgical patient care areas and (4) completed an NRP within the previous two years.

The recruitment of participants with a BSN and ADN supported the literature that while the nursing workforce has moved towards the BSN being the minimal degree requirement for all entry-level nurses,[11] the health care systems are still widely hiring ADN nurses. Next, sixty-one percent of nurses work in the hospital setting[12] and is currently where most NRPs exist, resulting in lucrative recruitment from this area. Finally, evidence suggests that many NRPs are one year in length, and NLRN satisfaction declines between six months and one year of practice.[14] Therefore, participants were interviewed following their NRP and within two years of experience to capture adequate time in the transition to practice phase.

Recruitment

IRB approval was obtained through Indiana University, Purdue University Indianapolis. Purposive sampling was used to recruit NLRN participants from various NRPs across the United States for information-rich cases.[79] A four-tier strategy was used to recruit NLRNs from a variety of NRPs: 1) social media, i.e., Facebook™, LinkedIn™, or Twitter™ recruitment 2) nursing organization, i.e., state and national nursing organizations, 3) professional contacts 4) individual NRP leaders.

Strategy 1a°

Three social media platforms were used to facilitate the recruitment of NLRNs from nursing-specific pages or feeds within Facebook™, LinkedIn™, or Twitter™. The administrators of the nursing-specific pages or groups were contacted using a recruitment letter to obtain approval for the study. The recruitment letter was then posted onto the specific Facebook™, LinkedIn™, or Twitter™ page, group, or feed with a link to a REDCap[82] survey to determine participant eligibility.

Strategy 1b

Study participants completed the screening survey through REDCap.[82] The participants who met inclusion criteria were contacted by email or phone, provided the study information sheet, and requested to send the study investigator the location and name of the hospital where the participant completed the NRP.

Strategy 2a

The second recruitment strategy included professional nursing organizations or alumni associations to access NLRNs. The PI contacted the state and national nursing organizations like the Indiana State Nurse's Association, Sigma Theta Tau International

Honor Society, and alumni associations to distribute the study recruitment letter via email or social media to their members.

Strategy 2b

A link to a participant screening survey through REDCap[82] was included in the study email for potential participants to complete. The participants who met inclusion criteria were contacted by phone or email and given the study information sheet and requested to send the study investigator the location and name of the hospital that the participant completed the NRP.

Strategy 3a

The third recruitment strategy included the study PI emailing personal connections in nursing to identify NLRN study participants. These personal contacts included RN's working in hospitals, faculty in schools of nursing, or hospital administrators, etc.

Strategy 3b

An email was sent to personal connections in nursing and included a link to the participant screening survey through REDCap[82] for the individual to distribute to NLRNs. The participants who met inclusion criteria were contacted by phone or email and given the study information sheet and requested to send the study investigator the location and name of the hospital that the participant completed the NRP.

Strategy 4a

The final recruitment strategy included contacting NRP directors via phone or email for support in recruiting participants from their program.

Strategy 4b

An email was sent to a few NRP directors and a link to the participant screening survey through REDCap for the individual to distribute to NLRNs. The participants who met inclusion criteria were contacted by phone or email and given the study information sheet and requested to send the study investigator the location and name of the hospital that the participant completed the NRP.

Data Collection and Management

Participant interviews were conducted using the Indiana University password protected Zoom Health Technology, a secure online web collaboration tool for meetings that entail confidential information exchange. Zoom Health Technology allowed for interviews to be conducted remotely. Before starting the interview, the investigator reviewed the procedures, risks, and benefits of the study and informed the participants that participation was voluntary, information was confidential, and they may end participation at any time. The ethical principle of do no harm was employed throughout the data collection and management process.[83] The interview took approximately one hour to complete, and a semi-structured interview guide with open-ended questions was used to obtain the "who, what, and where of events or experiences or their basic nature or state"[79] (pg 338) meeting the study aims. A demographic survey was distributed at the end of the interview. Each participant received a gift card for their time.

The interviews were recorded using Zoom Health Technology and downloaded into the Indiana University password protected Box Health and accessible only to members of the research team. Each participant was aware that the interview was recorded for analysis purposes. A trained transcriptionist transcribed all interviews. The

investigator reviewed all interviews for accuracy. Following transcription, all data were de-identified and stored within the Box Health file for analysis.

Data Analysis

Content analysis was used to analyze the data in the study. Data analysis was conducted by the investigator with assistance from a member of the dissertation committee with qualitative expertise. A conventional content analysis was conducted in which codes and categories were derived inductively from the data and summarized for the results. The following steps were implemented for data analysis.

Step 1: Transcript Review

The investigator read through all transcripts several times to become familiar with the participants' overall experiences in the NRPs and created a series of memos reflecting her initial thoughts about the meaning of the data related to the study aims.

Step 2: Extraction of Text Units

The investigator highlighted and extracted each relevant text unit. A relevant text unit was any word, phrase, sentence, or story that revealed an NRP attribute that a participant viewed as influential in his or her transition to practice.

Step 3: Coding

The investigator assigned a code to each text unit. Codes are brief labels that represent the substance of the participants' responses. The committee member verified the codes.

Step 4: Creating a Data Display Table

The investigator placed each code in a case-by-topic data display table.[83] In the case-by-topic table, cases (identified with participants ID numbers) appeared on the

vertical axis, and major topics related to the research aims (persons, activities, and structural elements of the NRPs) appeared on the horizontal axis. Codes were then displayed in the correct cells (e.g., participant 003 X classroom sessions). The investigator's committee member verified the placement of codes.

Step 5: Categorization

The investigator then used a series of variable-by-variable data display tables[83] to categorize the codes. For example, a table was created that listed each type of person associated with the NRP (e.g., director, educator, preceptor) on the horizontal axis and a variety of types of personal characteristics noted in the data (e.g., supportive/unsupportive, friendly/unfriendly) on the vertical axis. Codes were again placed in the appropriate cells. The final categories were determined by summarizing the codes in each cell. This process occurred through discussion and consensus with the committee member and a frequent return and reexamination of the original transcripts for modification and verification of the categories. The investigator maintained a series of memos throughout this process to chronicle all analytic decisions.

Step 6: Narrative Summary

To address the study aims, the investigator wrote a narrative summary of each category using verbatim participant quotes as supporting examples. The summaries were reviewed by the committee member and the dissertation chair. The investigator also prepared two exemplar case studies, one reflecting a positive NRP experience and one reflecting an NRP experience that was negative to begin with but improved over the course of the program, The case exemplars show how the categories were manifested in the context of the participants' overall NRP experiences.[83]

Evaluation

The scientific rigor of the study was enhanced by using several procedures.[81] The investigator conducted in-depth interviews in which participants were encouraged to freely describe a wide range of experiences in the NRP. Interviews were transcribed by a professional transcriptionist and verified by the investigator. Throughout all phases of the analysis, the investigator maintained a series of memos reflecting all analytic decisions, and these memos provide a detailed study audit trial. Peer debriefing with the committee member was carried out through regular meetings throughout the analysis process. The investigator regularly reexamined the original transcript data when constructing the findings, and verbatim participant quotes were used to support all findings. For consumers of the findings to determine if these study results apply to their settings, the investigator provides a detailed description of the participants and the NRPs that they completed.

CHAPTER 4

The results of the content analysis conducted for this study are presented in this chapter. Chapter 4 includes a description of the study sample, the interviews, and the components of the nurse residency programs (NRPs) that participants reported influenced their transition to practice, including the persons associated with the NRP, the activities comprising the NRP, and the structural elements of the NRP. The chapter also presents two case exemplars that demonstrate the influence of all components on the participants' overall experiences in their NRPs.

Results

Sample

Twenty nurses participated in the study. Sixteen (80%) were between the ages of 23 and 30; two (10%) between the ages of 41 and 50; one (5%) between the ages of 18 and 22; and one (5%) between the ages of 31 and 40. Sixteen (80%) participants were White, two (10%) were Black/African American, and two (10%) were Asian/Asian American. Eighteen participants (90%) were women, and two (10%) were men. Fourteen participants (70%) had a bachelor's degree in nursing, four (20%) had an associate's degree in nursing, and two (10%) did not report degree type. Fourteen participants (70%) completed a traditional four-year nursing program, five (25%) completed an accelerated nursing program, and one (5%) did not report the type of program. The participants had between 5 to 27 months of experience, with an average length of 16 months.

The participants completed nurse residency programs (NRPs) in the following regions of the United States: Midwest (seven participants, 35%) South (six participants, 30%) West (four participants, 20%) and Northeast, (three participants, 15%). The

participants completed a variety of different types of NRP models. Fifteen participants (75%) completed a facility-based model (FBM) program; eight (53%) of these programs had a Magnet designation, and three (20%) had ANCC accreditation. Five participants (25%) completed an evidence-based model (EBM) program; four (80%) of these programs were Vizient/AACN models, and one (20%) was a Versant NGNR. Of the EBM programs, four (80%) had Magnet designation, two (40%) had ANCC accreditation, and one (20%) had CCNE accreditation.

Description of Interviews

The interviews lasted between 45 and 90 minutes, with an average of 60 minutes. Eighteen participants chose to be interviewed with video and two with audio. All participants openly shared their experiences with their NRPs and provided considerable detail about their time in the programs. Several stated they were interested in research and participated in the study due to their desire to see improvements made in NRPs. A few indicated they chose to participate because they had exceptionally positive or, conversely, exceptionally negative experiences with their NRPs. In several cases, participants became quite emotional during the interviews. Some who had negative experiences appeared to be anxious and angry, and some who had positive experiences smiled or laughed during the interviews.

When describing their experiences with their NRPs, the participants focused on three components: 1) persons associated with the NRP, 2) activities comprising the NRP, and 3) structural elements of the NRP. For each of these components, the participants identified the types of persons, activities, and structural elements that were important and the attributes of each type that influenced their transition to practice. The program

components; the types of persons, activities, and structural elements that comprised each component; and attributes that facilitated or hindered transition to practice are discussed below.

Persons Associated with NRP

The participants described a variety of persons associated with their NRPs who influenced the participants' transition to practice. These persons included NRP directors, unit leaders, educators, preceptors, mentors, peers, and colleagues. Participants indicated that the personal characteristics of these persons either facilitated or hindered their transition to practice. Persons who facilitated the participants' transition were supportive, friendly, available, communicative, and expert. Persons who hindered the participants' transition to practice lacked these personal attributes. The types of persons and their attributes that influenced the participants are described below.

Directors

Sixteen participants described characteristics of NRP directors that facilitated or hindered the participants' transition to practice. The participants used various terms to refer to NRP directors, including facilitators, coordinators, managers, and leaders. For this report, the term director is used as it generally relates to persons in charge of organizing and implementing programs. The influential characteristics of NRP directors, as identified by the participants, are described below.

Supportive/Unsupportive. The participants indicated that the extent to which the NRP directors were supportive of the participants influenced their adjustment to the program. Many viewed their NRP directors as supportive and referred to them as "helpful," "comforting," and "encouraging." In some cases, participants used maternal

terms when describing a director. For example, one participant remarked that the NRP director was "like a mom to all of us." The participant said, "We all felt very comfortable going to her…she sat with us as we were talking …. She even shared her experiences." Some participants described how their directors provided support by creating a "safe space" for discussing any challenges experienced during the NRP. For example, one participant described how a director provided such a safe space for the participant to seek advice on transferring units. In contrast, one participant viewed the NRP director as unsupportive. The participant noted how the director stifled group discussions by asking questions without "intervening to provide follow-up support."

Friendly/Unfriendly. The participants also indicated that how friendly the NRP directors were influenced how welcomed the participants felt. Many participants viewed directors as friendly if they were "open," "nice," "outgoing," and "caring." The participants suggested that having a friendly director made them feel welcome to the program and the institution. For example, one participant remarked that the NRP director's "warm and welcoming" manner created a sense of security, and another claimed that being "friendly" was an ideal characteristic of NRP directors. No participants indicated that their NRP director was unfriendly.

Available/Unavailable. The participants indicated that the degree of availability of the NRP directors influenced the extent to which participants felt valued as residents. Participants viewed directors as available if they were "attentive" and "accessible." Participants remarked that NRP directors who were present and active in NRP sessions made themselves accessible by email, assisted the participants on their units if needed, and scheduled individual meetings with them, which signaled to the residents that they

were important to the institution. One participant stated, "She [NRP director] was someone else to talk to if somebody on our floor wasn't able." Conversely, a few participants viewed their NRP directors as unavailable and referred to them as "busy" and "not present." One participant revealed she had "minimal interaction" with the NRP director, felt the director did not know her and had only infrequent meetings with the director. The participant attributed this to her large NRP cohort: "I only saw her [director] every now and then, and so she probably doesn't even know who I am."

Communicative/Uncommunicative. The participants also indicated that how communicative the NRP director was influenced the extent to which participants had opportunities to process their experiences as residents. Many participants viewed their NRP directors as communicative because they communicated in a clear, direct, and nonthreatening way. The participants welcomed how these directors "facilitated discussion," "normalized feelings," and "encouraged and answered questions" when communicating with nurse residents. For example, one participant described how the NRP director facilitated the group discussion by ensuring the conversations were meaningful and engaging for the whole group and thus contributed to their learning. The participant stated,

> "Our director of our residency program… she knew how to facilitate us and where to lead it [the discussion]. If someone were hogging the conversation, she'd try and stop it a little bit and say, 'Oh well maybe if we get a chance, we'll come back to you at the end...'"

Conversely, one participant described a director who communicated poorly when leading group discussions and thus impeded the sharing of experiences. This director only asked the participant to talk about "cool" experiences they had, which led to conversations that

lacked depth and critical reflection. The participant wished the director instead had asked the group to discuss a tough situation or an experience that made them feel proud.

Having Expertise/Lacking Expertise. The participants also indicated that the extent of the NRP directors' expertise influenced the participants' abilities to begin to develop their own expertise. Some participants noted their NRP directors had advanced skills and knowledge and referred to them as "resourceful" and "good educators." The participants suggested that because of the directors' expertise, they were able to challenge the participants' thinking and enhance their clinical expertise. One participant stated,

> "She [director] was there to facilitate the discussions and also chime with expert knowledge if needed. Usually, she would challenge us, 'Okay, when this happens, what are you going to do, and what are you going to do next?'…That was very helpful."

No participants discussed NRP directors who seemed to lack expertise.

Educators

All twenty participants described characteristics of educators that either facilitated or hindered the participants' transition to practice. For this report, educators were persons associated with the NRP who provided instruction or education to the nurse residents. They taught nurse residents on the unit, in the classroom, or the simulation lab. Educators could be nurse educators, guest speakers, or interdisciplinary colleagues. The influential characteristics of educators, as identified by the participants, are described below.

Supportive/Unsupportive. The participants indicated that the extent to which the educators were supportive of them influenced their learning. Many participants viewed the educators as supportive and referred to them as "helpful," "understanding," and "encouraging." The participants suggested that the educators who encouraged the participants were helpful because a personal connection with educators facilitated

learning. One participant stated, "You need support, and you want people that are demonstrating that support when you're starting off as a nurse. You want people rooting and cheering you on, I think that is the most important thing." Conversely, one participant described an educator as unsupportive because she did not form a connection with the participant, which interfered with her learning. The participant stated,

> "The people that were involved that made a difference for me were people [who]…demonstrated that they wanted me to succeed versus someone that I didn't know from Adam who would come in, give us a presentation, ask for any questions, and then leave. That person is not invested in my success."

Friendly/Unfriendly. The participants also indicated that how friendly the educators were influenced how comfortable the participants felt when learning new material and skills. Many participants viewed educators as friendly because they were "warm," "welcoming," "open," "nice," and "outgoing." The participants suggested that these educators were relatable, which was especially crucial as participants often felt vulnerable because they were new to their role. One participant stated, "She's [an educator] a very kind person, very warm presence, and very understanding that we're brand new and literally don't know anything." On the other hand, a few participants described educators as unfriendly. These participants indicated that some educators were not engaging or open and came across as "flat." This demeanor discouraged interactions and made the participants uneasy. One participant stated,

> "He [educator] was kind of closed off. Wasn't really asking if we wanted to ask questions. He just really wasn't open and receptive. It really didn't feel like he related to us."

Communicative/Uncommunicative. The participants also indicated how communicative the educators were influenced how the participants were able to grasp new material. Some participants described the educators as "good communicators" who

"explained [content] well," while others remarked that the educators "encouraged and answered questions." One participant described how guest speakers who communicated information in a straightforward manner improved how the participant absorbed the material. She explained:

> "I think everyone explaining things in a really simple way that was easy to understand. Not expecting anybody to grasp anything right off the bat was very helpful. Just being very engaging, welcoming a lot of questions."

Another participant described how a guest speaker communicated information through a "clear, concise, and eloquent" presentation style. No participants described educators as uncommunicative.

Having Expertise/Lacking Expertise. The participants also indicated that the level of expertise of the educators influenced the participants' learning experiences. Most participants described educators as having high levels of skills and knowledge and referred to them as "experts" and "good educators." One participant stated the educators were the most important persons in the programs because they had "a huge trove of knowledge." Another participant credited the expertise of a guest speaker for the participant "upping his game a little" with patient care. He stated,

> "She's [guest speaker] one of the smartest people you'll ever meet… she a hundred percent knows her game, the research, the numbers…It was one of the best lectures I've had."

In contrast, another participant noted how inexperienced guest speakers can hinder learning by not adequately delivering critical information in an engaging or interesting way.

Preceptors

Twelve participants described characteristics of preceptors that facilitated or hindered the participants' transition to practice. For this report, preceptors are the

registered nurses who were specifically assigned to the participants and responsible for their clinical education throughout the NRP. The participants mentioned preceptors less frequently than other persons because some NRPs do not include a preceptorship component. The influential characteristics of the preceptors, as described by the participants, are described below.

Supportive/Unsupportive. The participants indicated the extent to which the preceptors were supportive of them influenced the participants' sense of confidence. Many viewed their preceptors as supportive and referred to them as "helpful," "understanding," and "encouraging." The participants suggested that preceptors who were "non-judgmental," "compassionate," and "accepting" increased the participants' level of confidence when they experienced trying situations in providing patient care or adjusting to their units. For example, one participant who had a negative interaction with a colleague said,

> "This person kind of made me feel dumb for asking this question, but my preceptor was also right there…to give me that support that I needed and helped me feel a little bit more confident."

In contrast, some participants viewed their preceptors as unsupportive. The participants especially felt unsupported if a preceptor took over the care of their patients or completed the participants' work as this deprived them of an opportunity to develop their skills or left them feeling incompetent. A few participants said they felt unsupported because a preceptor did not form a bond with them and showed little interest in being a preceptor. For example, one participant stated,

> "They [directors] basically force people to be preceptors. She [preceptor] didn't want to be doing it in the first place, she made it very clear that she didn't want anything to do with being a preceptor and she didn't enjoy it, and I didn't grow."

Another participant described what it felt like working with an unsupportive preceptor:

> "A lot of times she would tell me to do something and expect me to go do it and then kind of leave me to my own devices, where I felt I was treading water in an ocean by myself."

Friendly/Unfriendly. The participants also indicated that how friendly the preceptors were influenced the participants' attitudes about their preceptorship experience. Some participants viewed their preceptors as friendly and referred to them as "kind," "nice," "positive," "not condescending," and "patient." Participants suggested that preceptors who were friendly tended to be enthusiastic about teaching. One participant said, "He [her preceptor] was always ready to jump in, loved to teach, was so excited to have a new nurse to precept…he was really ready to teach me a lot of stuff." In contrast, a few participants viewed their preceptors as unfriendly and remarked how they were "negative," "moody," or "angry." Moreover, the participants revealed these preceptors often acted in ways that were "demeaning" and "condescending." In a few cases, participants had such poor experiences with preceptors that they requested a transfer to another unit.

Communicative/Uncommunicative. The participants also indicated that how communicative the preceptors were influenced how the participants learned to address problems and develop clinical judgment. Some participants viewed their preceptors as communicative because they communicated in an open and straightforward way that helped the participants work through challenges. For example, one participant remarked that the preceptor had a "direct communication" style that helped the participant prioritize nursing care. Participants viewed preceptors as uncommunicative if they were unable to convey information and advice to facilitate the participants' clinical practice. One stated, "She [preceptor] would constantly say 'I don't know how to help you. She would watch

and just make faces and smirk." The participant also stated, "I would ask her [preceptor] questions and she'd go 'Don't you remember we talked about that the first week?'"

Having Expertise/Lacking Expertise. The participants also indicated that the degree of expertise of the preceptors influenced the participants' clinical learning. Many participants viewed their preceptors as having high levels of expertise and referred to them as "trained," "competent," and "confident." The participants indicated that preceptors needed expertise both as clinicians and as preceptors to pass on knowledge and skills to nurse residents. One participant, who appreciated having a preceptor with little experience early in the program because the preceptor was relatable, was later assigned a more experienced preceptor. The participant said,

> "She [inexperienced preceptor] was very good at teaching as well… as the residency progressed, I took more and more challenging patients, it [getting an experienced preceptor] came at the right time, because I was really able to dive into the patho[physiology]."

In contrast, a few participants believed their preceptors lacked knowledge or skills either as a clinician or as a preceptor and thus served as "poor role models." For example, one participant described a preceptor who was a highly experienced nurse but who had never precepted a new nurse before and thus was at a loss to teach the participant basic skills like doing Intravenous (IVs) catheters or dressing changes. The preceptor instead was critical of the participant about "little things here and there," which made the participant self-conscious. The participant transferred to a different unit where she worked with an experienced preceptor and was able to regain confidence.

Peers

Seventeen participants described characteristics of peers that either facilitated or hindered the participants' transition to practice. For this report, peers are considered other

nurse residents who were part of the participants' residency cohort. The influential characteristics of peers, as identified by the participants, are described below.

Supportive/Unsupportive. The participants indicated that the extent to which the peers were supportive influenced the participants' sense of belonging and comfort in the program. Many viewed their peers as supportive and described them as "helpful," "comforting," "validating," and "reassuring." Several participants revealed that their peers provided a support "network," and the residency cohorts often formed strong bonds. This support decreased feelings of isolation because the participants realized they were "not alone" in facing the challenges of being a new nurse and could "go to each other for anything." The participants thus felt that their relationships with peers helped participants begin to feel more confident. One participant stated, "I could hear [during group sessions] …how they [peers] were struggling with certain things, and I could relate…and everybody was like there for me." The participants especially appreciated it when peers "opened up" about their feelings as this created a sense of camaraderie and closeness. For example, one participant revealed how helpful it was to discuss emotional issues like death and dying with peers. Conversely, some participants did not have an opportunity to interact and bond with peers and thus felt disconnected. One stated, "I didn't have those people who are on the same level as me and understood what we were all going through."

Unit Leaders

Many participants described characteristics of unit leaders that facilitated or hindered the participants' transition to practice. The participants referred to these individuals as unit managers, charge nurses, and clinical staff leaders. For this report, unit leaders are considered those who have managerial responsibilities for the units on which

the nurse residents engaged in clinical practice. The influential characteristics of the unit leaders, as described by the participants, are described below.

Supportive/Unsupportive. The participants indicated that the extent to which the unit leaders were supportive influenced the participants' sense of comfort in their assigned units. Many viewed unit leaders as supportive and described them as "helpful" or like a "cheerleader." A few participants referred to the unit leaders as "maternal," while other participants indicated the unit leaders made them feel "safe." For example, one participant described how she felt "coddled" by her unit leader because she spent a lot of time debriefing with the participant, which contributed to the participant "feeling seen and heard." The participant suggested that this unit leader was "really good for retention and just keeping people." On the other hand, a few participants viewed their unit leaders as unsupportive, describing them as "intimidating" and "detached." One participant remarked that she felt "a little intimidated" to talk to her unit leader about emotional challenges she faced with patients on the unit and described how the unit leader called the participant "unprofessional" for not sharing her problem sooner. This behavior caused the participant to be "distrusting of management" going forward. The participant transferred units a few months into the NRP and described feeling "more comfortable" and supported by the new unit leader.

Available/Unavailable. The participants indicated that the degree of availability of the unit leaders influenced the participants' experiences in their units. Some viewed unit leaders as available and described them as "present." For example, one participant noted the unit leader was "very present" on the unit, and her accessibility was comforting to the participant. Conversely, a few participants viewed their unit leaders as unavailable

and described them as "extremely busy" or as having a "hands-off" approach." One participant noted that the unit leader was "a little bit too busy to build a relationship with every nurse." Because the unit leader was unavailable, the participant was unable to discuss issues she was experiencing with her preceptor.

Communicative/Uncommunicative. The participants indicated that the degree of communicativeness by unit leaders influenced the extent to which participants felt guided in their work. A few viewed their unit leaders as communicative because they "encouraged or answered questions", provided feedback, and listened to the participants' concerns. One participant explained how her unit leader provided immediate feedback during patient rounds and how this taught the participant to communicate well with an interdisciplinary team. In contrast, a few participants viewed their unit leaders as uncommunicative because they had "unclear" communication or provided little feedback. For example, one participant shared how her unit leader did not provide adequate feedback during meetings, which left the participant feeling that she had little direction. The participant stated,

> "It was kind of difficult because even if I'm doing something wrong or not well enough, I want that kind of feedback. I want to be told, "Why don't you try doing this…"

Mentors

Six participants described the characteristics of mentors that facilitated or hindered the participants' transition to practice. For this report, mentors are considered persons who are not responsible for the nurse residents' clinical practice and have no role in evaluation but are assigned to nurse residents solely to provide guidance and support. Only a few programs assigned mentors in this capacity. The influential characteristics of the mentors, as described by the participants, are described below.

Supportive/Unsupportive. The participants indicated that the extent to which the mentors were supportive influenced how comfortable the participants felt about sharing their concerns as new nurses. Some viewed their mentors as supportive and described them as "helpful," "encouraging," "understanding," and "reassuring." Because the mentors were not responsible for the nurse residents' clinical practice, the participants regarded the mentor as an "outside" resource and ally who helped participants feel comfortable and successful. For example, one participant said,

> "They [the mentors] were just there to check up on you … working with you specifically in what you're having issues with as far as your transition … just a party that was outside of what was directly going on at work, so that you could talk to them in a nonthreatening way."

The participants appreciated the informality of mentoring relationships because they were able to share their experiences and concerns openly. One participant said,

> "We [she and her mentor] went on a hike, it doesn't have to be like an actual meeting…just getting together and kind of talking about how things are going on the unit, if there's anything I have questions about, anything going on in my transition that I'm not doing well with or anything, and she just offers her support and can direct me to the right people if need be."

No participants viewed their mentors as unsupportive.

Communicative/Uncommunicative. The participants also indicated that how communicative their mentors were influenced the participants' sense of reassurance that they were doing well. A few viewed their mentors as communicative because they "provided feedback" or "encouraged and answered questions." One participant felt she could go to her mentor "for anything" because she "easy to talk too." Another participant said,

> "I would text and talk to my mentor, and that at least, it wouldn't tell me exactly how I was doing, but it made me feel more comfortable because I would talk to her, I'd tell her what I was doing, and she would give me feedback."

No participants viewed their mentors as uncommunicative.

Having Expertise/Lacking Expertise. The participants indicated that the mentors' degree of expertise influenced the participants' own goals and aspirations. A few indicated that their mentors served as "good role models." One participant described how she admired her mentor because he was "cool, calm, and collected" in managing challenging patients due to his 30 years of experience. The participant explained how she wanted "[someone] to model myself after." She said her mentor was

> "honest about having his frustrations with patients and having his bad days…and not knowing what's going but also to see there's something beyond that, and still get through that."

No participants viewed their mentors as lacking expertise.

Colleagues

Twelve participants described characteristics of colleagues that facilitated or hindered the participants' transition to practice. For this report, colleagues are individuals that the participants worked with on their units but had no formal responsibilities in the NRP. The influential characteristics of the colleagues, as described by the participants, are described below.

Supportive/Unsupportive. The participants indicated that the extent to which the colleagues were supportive of them influenced the participants' overall experiences on the units. Many viewed colleagues as supportive and described them as "helpful" and "encouraging." A few participants referred to their colleagues as being "close" or "like a family." For example, one participant described how her colleagues served as her "professional family" by watching out for her. The participant said,

> "They're [colleagues] checking in on you constantly. They're making sure that you're doing okay. They're asking how they can help…. I can't stress how important that is…with that culture of teamwork, that has made my transition substantially easier."

On the other hand, several participants viewed their colleagues as unsupportive, referring to them as unhelpful and complaining they did not create "a family feel." For example, one participant described how her colleagues "didn't really want to help each other," which caused her to feel "terrified to come off orientation" because she would not have any support. She said, "For the most part, it was like you take care of your patients and leave it…everyone was doing their own thing basically on that unit." As a result, the participant requested a transfer to a new unit.

Friendly/Unfriendly. The participants indicated that how friendly the colleagues were influenced the participants' sense of belonging on the unit. A few viewed their colleagues as friendly, referring to them as "open," "welcoming," "positive," and "non-judgmental." The participants felt welcomed by these colleagues, allowing the participants to focus on acclimating to the unit rather than pleasing the colleagues. Conversely, some participants viewed their colleagues as unfriendly, noting they were "not welcoming," "negative," "cliquey," "gossipy," or "bullies." One participant described how her colleagues gossiped and laughed when others made a mistake. This "blatant adult bullying" resulted in the participant requesting a unit transfer in the first six months of practice. Another participant described how colleagues excluded new nurses from social gatherings. The participant said,

> "They [colleagues] were very cold towards one another. Some of them were friendly and would like to hang out outside of work… if you were a new nurse, you weren't invited into that clique. It was the nurses eat their young kind of mentality."

Communicative/Uncommunicative. The participants also indicated that how communicative their colleagues were influenced the participants' learning on their units. A few viewed their colleagues as communicative because they "explained [content] well"

and "encouraged questions." One participant shared how a physician explained the pathophysiology of a patient. The participant said, "He [physician] breaks it down into bite-sized pieces and builds on that until I understand." A few participants viewed colleagues as uncommunicative because they were unreceptive to questions. For example, one participant described how some senior nurses refused to answer her questions, and she thus grew reluctant to reach out to these colleagues with questions. Another participant described how a colleague, a dispatcher, refused to answer the participant's text messages requesting help with a patient. The participant said,

> "We [participant and another colleague] instantly started getting text messages that said, 'No. Go away from each other. No, you're not allowed to do that together.' And when I went down to our office where our dispatcher is, I could see that she was texting another experienced nurse saying, "Ha, ha, I broke up the group. I'm such a B.'"

Summary. The participants described various persons they encountered during their NRP experiences that either facilitated or hindered their transition to practice. The participants discussed persons formally assigned to the NRPs, including directors, educators, preceptors, and mentors. All programs had directors and educators, whereas not all programs assigned mentors and preceptors. The participants also discussed persons who were not formally part of the NRP but who had a significant influence on the participants' experiences, including unit leaders and colleagues. Peers in the NRP cohort also influenced the participants' experiences.

Regardless of role, the degree to which these persons were viewed as supportive by the participants had the most substantial influence on their learning, confidence, and comfort as new nurses. The influence of support offered differed by role. The support of directors and educators contributed to the participants' learning and confidence. The support of mentors and peers provided participants with opportunities to discuss their

concerns and emotions without judgment. The support of unit leaders and colleagues helped participants acclimate to their clinical units and their roles. Persons who were unsupportive, especially unit leaders, preceptors, and colleagues, could have detrimental effects on the participants' experiences. Moreover, persons, regardless of role, who were friendly helped participants feel welcome to their units or their institutions. Persons who were unfriendly, especially preceptors and colleagues, negatively influenced the nurse residents' experiences and, in some instances, resulted in participants requesting a transfer to a new unit. The participants were appreciative of persons, especially directors and unit leaders, who were available to them as this provided a sense of security as the participants developed new skills and became more confident in their practice. When these persons were unavailable, the participants felt insecure and apprehensive. The participants indicated that good communication skills and high levels of expertise were necessary for most persons associated with the NRP as this enhanced the participants' knowledge, confidence, and critical thinking. Persons who lacked these characteristics impeded the participants' learning and often contributed to their dissatisfaction, insecurity, and lack of growth. Overall, the emphasis the participants gave to their interactions with persons associated with their NRP experiences suggests that interpersonal relationships that nurse residents experience is critical to their overall NRP experiences and their transition to practice.

Activities Associated with the NRP

The participants described a variety of activities that comprised their NRPs and indicated that some attributes of the activities were helpful to their transition to practice, and some were unhelpful. The activities included classroom sessions, mentoring

activities, evidence-based practice projects, and shadow experiences. The activities and attributes are described below.

Classroom Sessions

All twenty participants described attributes of NRP classroom sessions that facilitated or hindered their transition to practice. For this report, classroom sessions refer to educational presentations or discussions held with a cohort of nurse residents that occurred outside of clinical practice experiences. Classroom sessions included the presentation of content, classroom activities, presentations by guest speakers, discussions of case studies, simulation experiences, and group discussions. The influential attributes of each of these types of classroom sessions are described below.

Presentation of Content. The participants indicated that specific content included in the NRP classroom sessions was either helpful or unhelpful to learning. For example, many participants reported that receiving information about the roles of interdisciplinary team members was useful as it promoted the participants' understanding of teamwork and increased their confidence in working with interdisciplinary colleagues. One participant stated,

> "I really got to know how everybody in the hospital works, not just the nurses, not just what we do, and how everybody works on their own, they have their own specific jobs."

Another participant indicated that she was more likely to use palliative and pastoral care resources after learning about these services. She explained, "I started using the chaplain a little bit more to help with people that just needed someone to talk to or needed to calm down." Other participants indicated that content on professional development was helpful because it encouraged them to plan their careers beyond the first year of practice. For example, one participant stated she liked classroom sessions on the topic of different

opportunities in nursing, such as roles in leadership and advanced education. Participants also remarked that being presented content on professional advancement suggested that the hospital was invested in their future. One participant said,

> "It [topic on professional development] made me want to stay. If they're [hospital leadership] gonna invest in me and want me, help me through doing all of this, then they want to keep me, so I would want to stay there if they're trying to help me advance my career."

Participants also found content on pharmacology, psychiatry, and patient de-escalation techniques helpful because it was relevant to their daily practice.

Many participants conversely indicated that some content included in the NRP classes was unhelpful because it was "repetitive," a "review," or "not applicable." One participant said, "I think it was stuff that I had already heard before, a million and a half times in nursing school." Some participants indicated the content was not memorable; one remarked that she could only remember the content from three out of ten sessions she attended. Some participants particularly objected to class topics related to self-care, including stress, burnout, and conflict management, because they were "too personal." Participants considered content on topics such as research, hospital policies and mission, and the electronic medical record as unhelpful because it did not have practical significance. Several indicated that the presentation of unhelpful content was especially problematic during the latter part of the NRP. One participant stated,

> "I don't feel I learned a whole lot from those [later] classes. I don't think I walked away with a whole lot of new knowledge…. At the beginning. I think I learned a lot, just from those skills classes and stuff, but coming back [later] as a whole cohort, I don't feel I learned a ton."

Classroom Activities. The participants also indicated that, in addition to content, classroom activities could be helpful or unhelpful for their learning. Most participants reported they learned more from classroom activities that were interactive or "hands-on."

They indicated that activities like an interactive charge nurse group activity, an escape room, a patient prioritization game, a group "get to know you" exercise, and a group self-evaluation assessment was especially helpful. They also appreciated activities aimed at skill practice and checkoffs as these activities increased their confidence and readied them for clinical practice.

Many participants, on the other hand, viewed classroom activities as unhelpful when they involved passive learning. Several complained about didactic presentations that included only PowerPoint presentations as this activity was "boring" and reminded them of being in nursing school. One participant stated,

> "I'm having to think a lot, being on the floor, but then being in class, especially if it's not interactive, I'm already in the zone of like, okay, I'm not going to have to be thinking I just have to absorb whatever they're saying."

Participants also found activities that included completing worksheets, online modules, or responding to article posts unhelpful.

Guest Speakers. The participants indicated that guest speakers could be helpful or unhelpful for their learning. Many viewed interdisciplinary guest speakers, like physicians, dietitians, or pharmacists, as helpful because they described their roles, provided practical advice, and provided resources that supported the participants' clinical practice. For example, one participant described how a pharmacist provided the nurse residents with a list of "quick references" to resources for their badges. The participant described how this provided reassurance and enhanced her autonomy over the first year of practice because she knew "who to call." Another participant shared that it was helpful when a guest speaker who was a respiratory therapy came to teach residents how to manage respiratory equipment.

A few participants, in contrast, viewed guest speakers as unhelpful. Participants remarked that guest speakers were unhelpful if they covered a topic that was not useful to the participant's practice, failed to provide practical examples, or were not the right speaker on the content. For example, one participant complained that having a guest speaker talk about bariatrics was not helpful because the participant did not care for patients who had this surgery. Another participant complained that a guest speaker on electronic medical records could not provide current scenarios to understand medical record entry. She said, "The examples and scenarios that we were working with were not something that we could immediately relate to, based on our preceptor experience." She claimed this resulted in "hours and hours of soul-destroying EMR entry practice."

Case Studies. The participants also indicated that the use of case studies was helpful or unhelpful for their learning. Case studies included the presentation and discussion of real or fictitious patient scenarios to teach the prioritization of nursing care. Some participants remarked that case studies were "impactful" because they supported critical thinking, increased knowledge, and improved confidence. One participant stated,

> "I think they're [case studies] great for giving an experience that could happen to you on the floor and being able to apply that when you're actually on the unit…because you can see if this happens, what is something that I need to do, and then you'll be able to remember that information."

A few participants viewed case studies as unhelpful. They objected to case studies that focused on professional development topics like conflict resolution or communication instead of those that focused on patients' clinical care. For example, one participant said,

> "I think we would go through these [communication-focused] case studies of like 'Here's the scenario, what do you do?' Obviously, you go and you talk to the provider and you get the situation figured out. Or obviously you tell the truth about making a medication error."

Simulation. The participants also indicated that the use of simulation was helpful or unhelpful for their learning. For this report, simulation includes the use of high or low fidelity mannequins or live actors to portray real patient scenarios in a simulated learning environment. Several participants viewed simulation as helpful because it allowed them to apply concepts learned in the classroom, enhanced their critical thinking, increased their confidence during their time on the units, and allowed them to gain familiarity with new procedures. Some described simulation as a valuable and "fun" way to learn. For example, one participant said,

> "Having that whole structure [class to simulation to practice] was really beneficial in letting you both understand and apply a lot of the topics that I needed to be successful in my unit."

Another participant described a week in which she did ten simulations each day and went from being "super stressed" to being a "well-oiled machine." Moreover, some participants indicated that simulation encouraged interprofessional practice, facilitated teamwork, and enhanced collaboration.

A few participants, on the other hand, viewed simulations as unhelpful. They described simulations in which equipment was inadequate, a debriefing was not included, or only clinical skills were demonstrated. Other participants described simulation as unhelpful because the experience made them feel "scared," "stressed," or "inferior." One participant described a code blue simulation in which her "kid" was dying because of equipment failure, and this threatened her confidence. She said,

> "[now] I hear the code alarm going off, I get really nervous, and I'm just like, I really hope that it's not for me… If I'm the bedside nurse, I think I just go into panic mode."

Group Discussions. The participants also indicated that the use of group discussion was helpful or unhelpful for their learning. For this report, group discussions

are times during the classroom session when nurse residents express their thoughts and ideas with cohort peers. Many found group discussions to be helpful as they were "comforting" and "encouraging" and provided a "safe space" or "sounding board" to share their experiences and concerns. During group discussions, participants had discussed their fears associated with making a medication error, having unsupportive colleagues, and the stressors of being a new nurse. One participant, who heard a colleague discuss a near-miss medication error in a group discussion, said,

> "I think sometimes as a new nurse you feel really isolated. You can't make any mistakes and it was very validating to hear … that story has stuck with me… It helps to validate that everyone is kind of nervous about mistakes and doing the right thing … by patients."

Some participants indicated that group discussions about the dynamics of the units and the workings of the institution were helpful. One stated that these discussions open her eyes to the way "everything worked" in the hospital.

On the other hand, a few participants indicated that group discussions were unhelpful. These participants viewed group discussions as a waste of time because they were disorganized or superficial. One participant reported that group discussions amounted to four hours of "just socializing." Some participants found group discussions to be unhelpful because they were not a safe space to discuss concerns. One participant said she was unable to discuss a negative experience she was having with her preceptor during a group discussion because it was not the group norm to share such problems, and, as a result, she felt "ostracized" from the group. She said, "No one's going to speak up and say, "Oh my preceptor is telling me I should quit.'"

Mentoring Activities

Four participants described mentoring activities that facilitated or hindered their transition to practice. For this report, the term mentoring activities included events arranged with a mentor, as defined above (in the section persons associated with the NRP). The activities could include individual or group get-togethers with the mentor. Few programs arranged mentoring activities, but participants who participated in them found them helpful. A few participants indicated that mentoring activities were helpful because they provided an opportunity to socialize with more experienced nurses, be with "like-minded people," and obtain support. For example, one participant who was assigned a mentoring group in which she was paired with "like-minded" people interested in leadership stated, "I looked forward to the meetings, and having that time, knowing that this is a time where we can share and talk about our experiences." One participant was assigned to a mentor who met the participant in a social setting for six three-hour meetings over the first year. The participant described how this arrangement provided her with the extra support needed to be successful as a second-degree nurse. Several participants identified the need for NRPs to more regularly integrate a mentoring component into the program.

Evidence-Based Practice Projects

Nine participants described attributes of evidence-based practice (EBP) projects that facilitated or hindered their transition to practice. For this report, an EBP project was a group task assigned to the nurse residents in which they were asked to identify an issue on their clinical unit, determine solutions to the problem, and present suggestions for

improvement to the unit with a poster or podium presentation. The participants indicated that the EBP projects were helpful or unhelpful for their learning.

Some participants found the EBP projects to be helpful and described them as "impactful," "valuable," "positive," and "interesting." The participants described doing EBP projects that included topics such as implementing Kangaroo Care in the neonatal intensive care unit or identifying causes of high turnover rates in nurses working on a medical-surgical care unit. Participants indicated that their EBP projects created new knowledge and provided useful information for their units. One participant's EBP project included recommendations to improve the retention of nurses, and while the recommendations were not all implemented, the participant said, "I think she [unit leader] maybe learned a little bit more about what was going on the floor and how to help make the transition from a new nurse or a nurse transferring from a different floor onto our floor a little bit smoother." Furthermore, some participants noted they experienced personal growth and enhanced confidence as a result of the EBPs. One participant said her EBP was "kind of a catapult to change my attitude and my practice… I'm going to start with me because right now, that's what I can fix is me."

Some participants viewed the EBP projects as unhelpful and described them as "annoying," "like school," a "burden," and "added work." Several participants found the EBP projects to be unhelpful because coordinating and carrying out the project with peers was time-consuming and inconvenient, and the write-ups and presentations were stressful. Others felt that they were not prepared to do the EBP project, especially if assigned early in the program, and they were unfamiliar with the practices on the unit. One said,

> "It's hard. I don't know how they [her unit] are doing things now. How am I supposed to say how they should do things? Others felt that the EBP did not help them develop practical clinical skills. One stated, "I don't think it's [EBP project] as beneficial to learning how to be a good nurse in practice."

Shadow Experiences

Three participants described attributes of the shadow experience that facilitated or hindered their transition to practice. For this report, shadowing is an experience where nurse residents rotate throughout the hospital to learn about different departments and members of the interprofessional team. Only a few programs included shadowing as an activity for nurse residents. The influential attributes of the shadow experience are identified below.

All three participants indicated that shadow experiences were helpful. These participants viewed the experiences positively because they were exposed to various units and introduced to how other interdisciplinary colleagues functioned within the hospital. This information enhanced patient care. One participant said,

> "Now I can now tell them [patients], okay, so when you go down, you're going to meet this person, she's going to do an echo. It's going to kind of go like this, whereas before I was just reciting what somebody else had told me, now I kind of have a full grasp of what they're going to experience."

The participants also indicated that shadow experiences decreased their fear of floating to other units and increased opportunities for "meeting and bonding" with other nurses and colleagues.

Summary. The participants identified the activities in the NRP that influenced their transition to practice. The primary activities they discussed occurred in the classroom sessions they were required to attend. The sessions could include activities, guest speakers, case studies, simulation, and group discussions. Generally speaking, they

indicated that the sessions were helpful if they included active "hands-on" learning and provided information that was of practical use to their everyday practice. Participants objected to activities that involved passive or disengaging learning, did not have practical significance, or felt like nursing school. Participants' reactions to EBP projects were mixed; some found them empowering and appreciated the opportunity to provide useful information for their units, whereas others found them to be time-consuming and inconvenient and felt poorly positioned to make recommendations to units with which they were not yet familiar. Mentoring and shadowing experiences were not common, but the participants who did have these opportunities found they provided support and useful information.

Structural Elements Associated with the NRP

The participants described structural elements of their NRPs that facilitated or hindered their transition to practice. In this report, structural elements refer to the overall way in which the NRPs were designed. The participants described two key structural elements of the programs: how the meetings were organized and implemented and how the preceptorships were organized and implemented. How these structural elements influenced the participants' transition to practice are described below.

The Organization and Implementation of Meetings

Nineteen participants described the organization and implementation of the NRP meetings that facilitated or hindered their transition to practice. For this report, meetings refer to any formal required gatherings of the nurse residents, including classroom sessions or meetings for other purposes (e.g., orientation meetings, mentoring meetings). The participants commented on the length of the meetings, the scheduling of the

meetings, and the sequence of the meetings. The influential attributes of the meetings are described below.

Length of the Meetings. Many participants commented on the length of the meetings and indicated that they believed that between three and six hours a week was ample time to spend in a meeting. For example, one participant indicated that that the three-hour meetings were not too long, another said four-hour meetings were the right length, but that she would not want them to be any longer, and another said six-hour meetings allowed enough time to learn and apply new knowledge in the classroom and the simulation lab. Other participants did not indicate that the meetings were too long, but some did complain that meetings added an extra burden to an already demanding schedule.

Scheduling of the Meetings. Some participants remarked that the meetings were helpful but only if they were scheduled at a convenient time. They especially liked meetings scheduled during their regular work hours as the meetings then offered a "nice break to get off the floor." On the other hand, many participants indicated that the meeting schedule was unhelpful because meetings were scheduled at a difficult time. For example, many participants complained that meetings were scheduled on their days off or following a night shift. One participant said,

> "I was zonked out [after the night shift], and I was full of coffee, and the reason I don't remember a lot of it [from the meetings] was because I was so tired at that point I really struggled a little to get there and just stay awake."

Another said she "dreaded them [meetings]" because she had to drive back to work on a day off after already working three full shifts.

Sequence of the Meetings. Several participants indicated that how the meetings were sequenced across the residency program was helpful to their learning. A few participants noted that having skill checkoffs early in the program was useful. For example, one participant remarked that the placement of a two-week skill-intensive at the beginning of the program created confidence to head into the preceptorship experience. Another participant noted that an early-on skill-intensive was especially beneficial because she did not get much hands-on clinical experience during nursing school. Others appreciated socialization opportunities when offered early in the program. One participant explained,

> "That two weeks [introductory meetings] was super-awesome, to grow relationships with each of them [peers] …when I started on the floor, I wasn't alone, I had friends."

Other participants indicated that how content was sequenced across the program was helpful. One said that she appreciated how there was a meeting on medical/surgical certifications at the six-month mark and a class on advanced education toward the end of the first year.

On the other hand, many participants indicated that the meetings were sequenced in a way that was not helpful. Several suggested that the sequence of the meetings interfered with their ability to apply knowledge. For example, one participant shared that because the meetings were planned after her preceptorship ended, she could not use the resources provided in the meetings over the first six months of practice. Another participant explained that having an advanced life support certification and emergency training at the end of the NRP left her feeling incompetent because she was "not technically certified" to provide adequate emergency care to her patients over the first year of practice. Other participants indicated that the meetings at the end of the

preceptorship ceased to be beneficial because they had become more focused on their role as a "new nurse." One participant described the meetings in the second half as repetitive and said, "[I] couldn't wait for it [NRP meetings] to be over."

Preceptorship

Nine participants described attributes of the preceptorship structure that facilitated or hindered their transition to practice. For this report, a preceptorship is a component of the NRP in which residents are assigned to a designated nurse (preceptor) who oversees the onboarding experience of the residents. As mentioned above, not all NRPs included a preceptorship. The participants commented on the number of assigned preceptors, the length of the preceptorships, the units where the preceptorships occurred, and the teaching strategies used during the preceptorships. The influential attributes of the preceptorship structure are described below.

Number of Preceptors. The participants indicated that the number of preceptors they were assigned could be either helpful or unhelpful. Some were assigned one preceptor throughout the preceptorship, whereas others were assigned several preceptors.

A few participants indicated that having two or more preceptors was especially beneficial because the participants could gain a variety of experiences and learn from the different "personalities" of their preceptors. One participant said,

> "One [preceptor] was very laid back, and one [preceptor] was a little bit more Type A. I think that's really helpful because I would learn so much and then I would really be able to just go at it on my own in a different setting or on a different shift."

Furthermore, a few participants noted that having two preceptors with different levels of experience was beneficial. One participant who had a novice and an experienced preceptor especially appreciated her novice preceptor. She said,

> "I think a lot of times nurses who are experienced kind of forget what it's to be a new nurse or think something is obvious, and it might not be."

A few participants said that having multiple preceptors with a variety of teaching styles and approaches to patient care enriched the participants' practice. One participant, who had eight preceptors, said,

> "I got to see how they do things and how they interact with the patients and how they prioritize and organize their nights… I really enjoyed, was getting to know and see all of these different ways. That way I could figure out what was going to work best for me and my practice."

On the other hand, several participants indicated that having multiple preceptors was unhelpful. A few participants indicated they had between four and eight preceptors, and this was disruptive because it made communicating with each one challenging. One participant who had six preceptors said he had to "play catch up in my assignments" by explaining to each new preceptor the goals he had accomplished with each patient. Other participants indicated that having multiple preceptors was problematic because each expected something different, and it was difficult to get to know them well. One participant described feeling like he lost out on developing a close relationship with a single preceptor.

Length of Preceptorships. The participants indicated that the length of the preceptorship could be helpful or unhelpful. The lengths of the preceptorships varied widely; participants had preceptorships that lasted as little as six weeks or as long as twenty-four weeks. Some participants felt the length of the preceptorship was adequate and prepared them for practice. A few participants who had a ten- to twelve-week preceptorship remarked the experience was long enough. Another participant who had an eighteen-week preceptorship said she was "nervous to be on [her] own" but felt comfortable enough to begin to practice independently.

Conversely, some participants thought the length of the preceptorship was not long enough to acquire the knowledge and skills necessary to feel confident to practice when the preceptorship was over. Whereas some participants felt a twelve-week preceptorship was adequate, others believed it was not long enough for them to feel ready to work independently and described feeling "terrified" to be on their own.

Clinical Unit Assigned for Preceptorship. Some participants indicated that the unit they were assigned to for their preceptorship on could be helpful or unhelpful. In some instances, participants were allowed to choose the unit to which they were assigned and in some cases they were not. Some participants were pleased with the units on which they completed their preceptorship because the people were friendly or the unit provided good learning opportunities. On the other hand, a few participants indicated that their preceptorship was unhelpful because of the unit. Some complained that the patient acuity and workloads on their assigned units were too demanding, leaving them overwhelmed. Others who rotated units indicated that the order in which they were assigned to units was not optimal. For example, one participant shared that he "rode a rollercoaster for three months" during the preceptorship because he did not have the opportunity to complete a rotation in a different ICU. He explained, "I think [peers who did the ICU rotation] were much better off just because they [cohort peers] got more experience."

Learning Experiences During Preceptorships. A few participants mentioned that particular learning experiences included in their preceptorships were helpful. Some said that shadowing their preceptor on the first day, a day and night shift preceptorship experience, or taking a "personality learning assessment" for preceptor matching were beneficial. One participant described how her preceptor used a "pyramid teaching style"

to build foundational nursing skills over time, and this was beneficial to learning organization and prioritization. Another participant indicated that being included in interprofessional rounds during the preceptorship enhanced her communication skills and confidence.

Summary. The participants identified two main structural elements in their NRPs that influenced their transition to practice: the organization and implementation of meetings and the preceptorships. They viewed meetings as helpful if they were long enough but not too long, scheduled at convenient times, and sequenced in a way that was optimal to their learning. They were particularly dissatisfied when meetings were scheduled at times when they were not at work or when meetings became redundant toward the end of the NRP. They viewed the preceptorships as helpful if they were assigned the right number of preceptors, the preceptorships were long enough so they felt confident beginning independent practice, and the preceptorship included particular activities such as shadowing and rotating shifts. They were particularly frustrated if the unit to which they were assigned for the preceptorship presented too many practice challenges and thus did not meet their learning needs as novice nurses.

Case Exemplars

While the aims of the study focused on identifying aspects of NRPs that influenced the participants' transition to practice, the participants' narratives revealed that it was often the interplay of these factors that determined whether the participants perceived the NRP to be helpful overall or not. To exemplify this interplay, the following section includes two case exemplars of participant narratives. One exemplar describes an NRP experience that was primarily positive (Participant A), and one exemplar describes

an NRP experience that was negative initially but improved with a unit change (Participant B). To protect the identity of the participants and the NRPs, some non-essential facts have been changed in the summaries**.**

Participant A

Participant A completed a one-year NRP in a non-accredited, facility-based, Magnet-designated health system located in the northeastern United States. She had a Bachelor in Nursing degree and had been practicing as a nurse for over a year at the time of the interview. She completed the NRP on a medical care unit.

Participant A described many people associated with the NRP and their influence on her experiences in the program, including a mentor, two preceptors, colleagues, NRP leaders, unit directors, and peers. Each of these individuals played a significant role in facilitating Participant A's transition to practice. The mentor mainly met with Participant A outside of the workplace but at times was also available to her on the unit to answer questions and provide resources. Participant A described this individual as a "good role model" because she was experienced and professional and treated the participant with kindness and respect. However, Participant A's preceptors had the biggest impact on her transition. They had extensive knowledge and leadership qualities, non-judgmental demeanors, and helpful teaching styles. Her preceptors encouraged her autonomy and learning by teaching her the "little things." In addition, Participant A's colleagues were welcoming, encouraging, and supportive and made her feel like she had a "family" when starting out as a new nurse. Moreover, Participant A's unit leader was available, supportive, and encouraging, which aided Participant A's day-to-day practice as a new nurse. Similarly, the NRP leader was "like a mom" who had an approachable and caring

demeanor. Furthermore, Participant A bonded well with her cohort peers, which made her feel connected and supported outside of the clinical unit.

Participant A described many activities in the NRP that helped her transition to practice. For example, the NRP classroom sessions included meaningful group discussions, informative guest speakers, and relevant content. Participant A looked forward to the classroom sessions because they were well organized and the content was "vast" and met her needs. Early in the NRP she spent most of her time in the class sessions and appreciated “simple” things like a hospital tour and skill check-offs. Later, the classes included more “strategic” content on topics like career advancement and advanced education. Each class session included time for open discussion among the cohort peers so they could discuss challenges they faced and how they coped with these challenges. Additionally, a rich interdisciplinary perspective was integrated into program with a wide variety of guest speakers and with shadow experiences. For example, Participant A found that having a variety of hospitalists explain “their side of things" helped her understand their roles as they related to patient care.

Participant A felt that the structure of her NRP was well-organized and strategically planned. She said, "I wouldn't have done anything different." For example, the program had a “front-loaded” approach to meetings to enhance socialization and classes tapered off once the preceptorship began. Participant A discussed how meetings were integrated into her work schedule, which provided a convenient schedule.

Participant A felt that several structural elements of the NRP significantly influenced her transition to practice. First, being assigned two preceptors rather than a single preceptor allowed her "to see how different people [preceptors] do things." In

addition, the overall NRP experience was individualized and well-organized. Participant A said the program was "preplanned out for every single one of us [nurse residents]." Moreover, the positive culture on her unit made Participant A feel "welcomed" and "comfortable." She said, "I never felt intimidated or nervous about anything…it was never scary to me because I had so much support." The exceptional experience she had in her NRP allowed her "to put my focus on advancing [as a new nurse]."

Participant B

Participant B completed a one-year NRP in a non-accredited, evidence-based, non-Magnet designated health system located in the Western United States. She had an Associate's in Nursing degree and had practiced as a nurse for a year and a half at the time of the interview. She completed the NRP in a medical float pool.

Participant B indicated that many people associated with her NRP had influenced her transition to practice in a negative way. Even before Participant B began her NRP, she encountered a nurse recruiter who provided little support and inaccurate information. For example, the recruiter did not inform Participant B that she was required to pass a competency exam to be on the unit. The recruiter's tone led Participant B to feel that she was "just here to fill a slot." As the result of a rushed and poorly executed recruitment process, Participant B chose a unit with no other new graduate nurses, which left her feeling very lonely.

Other persons who contributed to Participant B's negative experience included a preceptor, colleagues, NRP leaders, a unit director, and peers, many of whom she initially found to be unsupportive, unfriendly, or inexperienced. In particular, Participant B was bullied during her NRP. She described a preceptor who was demeaning and

condescending, causing Participant B to question her abilities, lose confidence as a new nurse, and become “petrified” to practice. Moreover, she did not receive support from NRP directors, unit leaders, and educators when this bullying occurred and she was forced to "rock the boat" to report the bullying. She also encountered "bullying" by her colleagues during the first six months of practice. Ultimately, Participant B transferred to a new unit and experienced a “360" change as she received support from her new unit leaders, preceptor, and colleagues. This support ultimately allowed her to regain her confidence.

Participant B also described many activities in the NRP that negatively influenced her transition to practice. She felt the NRP classes were not memorable, engaging, or informative because they covered topics she had had in nursing school. She objected to classes that used only PowerPoint presentations that did not hold her attention. She also did not like small group discussions because she did not feel comfortable sharing her negative experiences in the NRP and hearing her peers share their positive experiences only "made me [Participant B] want to leave [the unit] more." Participant B experienced some simulation experiences as "eye opening" but felt inferior to her peers who had a bachelor's degree and would "step in" to take over the simulation. The simulations did not include a debriefing and she wished the educators would have questioned why she “just stood in the corner and didn't say anything" or follow up "to work one on one" with her. Participant B did find some class content and interdisciplinary guest speakers to be useful.

Participant B found many structural elements of the NRP to be unhelpful. The NRP included six-hour class sessions each week for the first twelve weeks and then

monthly for a year, and she felt these classes were too long. Moreover, she had not been informed by the recruiter that the NRP structure did not include a unit rotation and resented being "locked into a department for a year." Furthermore, she felt that the NRP structure did not promote "bonding experiences" because meetings occurred in a large room and included little group work. Participant B experienced the NRP as "fumbling" from the very beginning because of lack of educators and turnover in NRP leadership.

Participant B revealed that the emotional toll the first six months of the NRP, during which she cried “all the time,” affected her psychological well-being and her confidence as a new nurse. She said, "I didn't know what I was doing, I couldn't get the help I needed and so patients could get injured." However, once she was transferred to the new unit, she "didn't even bat an eye" to be on her own because she received much support. Participant B described the second half of the NRP as an improvement because she felt more confident to "share" her story in small group discussions and felt empowered by an evidence based practice group project that resulted in a change in her new unit.

Because Participant B had both negative and positives experiences in her NRP, she was able to reflect on what make NRPs helpful. She claimed that a successful NRP experience depends on a resident "clicking" with a trained preceptor and the program having a well-organized structure with adequate and available NRP leaders, active and engaging learning experiences, and a mentorship program. She stressed that a negative NRP experience has lasting effects. She said,

> "It's our first year. You can't take that back. You can't gain it again. So, if the program doesn't really know what they're doing then none of us know what we're doing."

Summary

The participants indicated that a successful NRP has three essential components: persons who are welcoming and supportive and who teach residents well; activities that are engaging, interactive, and relevant to the residents' day-to-day practice; and a structure that provides optimal learning experiences that advance the residents clinical skills and adjustment to their roles. These three components can converge in ways that produce an experience that facilitates the residents' transition to practice or in a way that hinders it. Either way, an NRP is an integral part of the journey of new nurses and can have substantial, and perhaps enduring, effects on their personal and professional lives.

CHAPTER 5

Discussion

The following chapter includes the discussion, study limitations, and conclusions drawn from the completed qualitative description study. Future research goals are outlined, highlighting implications for education, practice, and policy.

Based on this dissertation project, there is evidence that nurse residency programs are positively and negatively influencing NLRNs as they transition from the academic setting into the practice environment. When NRP experiences are positive, the NLRN acquires new knowledge, gains confidence, builds relationships, and finds success socializing and transitioning into the new role. But, when those experiences are negative or suboptimal, the NLRN finds it challenging to gain new knowledge, struggles or fails to gain confidence, cannot form trusting relationships, and finds socializing and transitioning to practice difficult. The NRP experience for several NLRNs in this study was so negative that they requested to transfer to work on a different unit. This study's negative findings are significant as it negates the original intent and purpose of NRPs to enhance the transition to practice experience for NLRNs. The findings of the study are discussed according to the themes regarding all types of NRPs. The findings are not separated by the NRP type, as that was not the focus or aim of this study.

State of the Science

According to the integrative review and conceptual analysis, NRPs have evolved over the last 10 years, but in a fragmented way. Similarly, this study's findings revealed how the attributes described in NRPs vary greatly and are influencing NLNRs both

positively and negatively. Thus, the NLRNs in this study described how the people involved, activities included, and structural element designs varied in each NRP.

One important conclusion from the concept analysis is that not all NRPs are accredited by the two national nursing accrediting bodies by which programs are reviewed, evaluated, and standardized. This lack of accreditation oversight is different than other allied health profession programs. Unlike Graduate Medical Education, where every residency is standardized and accredited by the Accreditation Council for Graduate Medical Education (ACGME) with data included in a repository, nursing does not have this information on NRPs. According to the ACGME, 11,214 medical residencies exist as of 2018.[84] A similar search for the number of NRPs in the US is unclear and requires a manual search through individual healthcare systems or the two NRP accrediting bodies. Easily accessible information on NRPs is not available because there is no entity responsible for the program's oversight. The lack of accessible information was very apparent within the integrative review and evolutionary concept analysis findings. Therefore, the overall state of the science is limited. For a new graduate to participate in an NRP, they must research individual programs, and in some cases, relocate to complete a program. The lack of access to information and data regarding NRPs in the US complicates and stymies NLRNs from pursuing an enhanced post-graduate transition to practice experience.

The science on NRPs has evolved some over the last ten year. Most of the literature on NRPs consists of studies that included small samples, single sites, and descriptive study designs. Also, 60% of the studies in this dissertation project's integrative review were completed before 2015. As seen from the integrative review and

study, if most NRPs across the US are predominately facility-based models, then the state of the science will continue to be limited and lack generalizability across programs. More rigorous qualitative and quantitative research designs and more robust sample sizes and demographics are needed to advance the science of NRPs.

Qualitative Description Project

The findings in this qualitative description study are unique because the outcomes are from the NLRNs perspective. There are very few studies in the literature from the NLRN's perspective and just one from Clark and Springer (2012) in this dissertation's project integrative review. The similarities between this study and Clark & Spring (2012) include: 1) the positive impact of welcoming and supportive colleagues and environment, 2) the negative impact of unsupportive preceptors, 3) the positive and negative impact that access to people and resources has on stress, 4) the negative impact of poor and lacking communication with nursing and interdisciplinary colleagues, and 5) the need for more relevant and engaging topics like incivility, prioritizing care, delegation, and communication. Finally, both the 2012 study and the qualitative study presented in this dissertation describe the impact that supportive individuals have on NLRNs and, most importantly, that preceptors have a significant role in the transition to practice experience.[30] As with previous literature, the research findings in this qualitative dissertation project support the crucial impact that preceptors have on NLRNs that remains unchanged.

The qualitative dissertation project advances the science of NRPs. The findings from this study expand on Clark and Springer's (2012) study in several ways. First, this dissertation study included interviews from NLRNs in a variety of

healthcare systems and different types of NRP models around the US. The Clark and Springer study was limited in scope by the perspectives of NLRNs from one healthcare system. Next, this study used one on one interviews with NLRNs who had completed the NRP, while Clark and Springer (2012) used focus groups for data collection with nurses who had between eight days and nineteen weeks of experience. Thus, the data collected in a group setting and from nurses with minimal perspective limits the study findings. Finally, while the findings from Clark and Springer (2012) outline the transition to practice experience from the NLRNs perspective in an NRP, there is no discussion about the NRP by the participants. Instead, the findings reveal typical challenges most NLRNs experience during transition to practice and not expanding the science of NRPs.[30] Unlike much of the literature on NRPs, this dissertation project added the perspective of the NLRNs as it relates to the established components of NRPs. Also, participants provided expansive details about the attributes of NRPs that are positively or negatively influencing the transition to practice.

Next, this study provides additional insight into the outcomes reported in the integrative review studies, like how NLRNs satisfaction, stress, or confidence may be impacted by participating in an NRP. Thus, this qualitative study not only expanded on the influential components of NRPs, but provided information about the positive and negative attributes of the people, activities, and structural elements of NRPs. The next section will summarize in detail conclusions from each of the three components people, activities, and structural elements of NRPs found from the qualitative findings.

Summary of Themes: Persons Associated with NRP

Based on the findings of this qualitative study, the people involved in NRPs had the most significant influence on the success of the NLRNs. This study supports that the people involved in NRPs need to have specific interpersonal and communication attributes to impact an NLRN feeling accepted, connected, care about, and welcomed. The interpersonal qualities of the person vary according to their role in the NRP. First, feeling supported by everyone the NLRN encounters during the NRP was an overarching theme influencing a positive transition to practice. Thus, when an NLRN described individuals in the NRP that were unsupportive, then feelings of incompetence, lack of confidence, acceptance, and fear were reported.

The theory of Transition Shock substantiates the overarching theme of support reported in the study. New nurses' experiences are dominated in the first four months of practice. The following quote on Transition Shock validates this theme.

> "finding and trusting their [new nurse] professional self, distinguishing those selves from the others around them, being accepted by the larger professional culture, balancing their personal lives with their professional work, and finding a way to meld what they learned during undergraduate education with what they were seeing and doing in the 'real' world"[2] (pg. 1108).

Therefore, when NLRNs are supported by NRP directors and educators, unit leaders, peers, colleagues, mentors, and preceptors during the NRP, have a greater sense of self and less transition shock.

Next, when NLRNs encountered negative interpersonal interaction with any individual in the NRP, there was an increased risk of adverse outcomes such as anxiety, fear, isolation, and lack of confidence. The Transition Shock theory substantiates this finding in NLRNs stress and anxiety because of inadequate emotional and functional

support.[2] Therefore, NRP leaders should be selectively identifying individuals with enhanced interpersonal, relational, and communication capabilities to improve the success of the NLRN over the first year of practice.

NLRNs identified the most impactful people they encountered in the NRP: NRP directors, unit leaders, educators, preceptors, mentors, peers, and colleagues. Each of these individuals influenced the NRP experience in various ways. Still, the collective team of individuals had the most significant influence on an NLRNs first year of practice. Thus, a breakdown in any of these roles, then the NLRN increased the risk of adverse outcomes. Therefore, the roles of the people involved in the NRP need to be clearly defined, communication and feedback should be consistent, and a unified commitment to the success of the NLRN is essential.

The study's findings further confirm the impact that preceptors and colleagues have on the positive or negative experience for NLRNs. Preceptors and colleagues possess great potential to impact NLRNs confidence, feelings of acceptance, and how they view the first year of practice. For example, several participants in this study described interpersonal experiences with preceptors and colleagues that resulted in the NLRN requesting a unit transfer during the NRP experience. This finding is supported in the Clark and Springer (2012) study where NLRNs reported increased stress levels for "disinterested or unsupportive preceptors" (pg 5). The profound impact preceptors have on NLRNs is just as apparent today. Thus, NRP directors need to consider prioritizing the assessment, qualifications, and training of the preceptors involved with NLRNs. Preceptors need to possess the interpersonal qualities identified by the NLRNs in this

study and need specific training on teaching and learning strategies, role socialization, communication, and feedback.

In previous research, NLRNs report that colleagues influence the transition to practice experience.[25,31,41,42] Colleagues are often defined as individuals who work with the NLRNs on the clinical units but have no formal responsibilities. NLRNs from this study reported that the colleagues they encountered greatly influenced how much energy and focus the NLRN spent on feeling accepted or isolated, energized or depleted, and ultimately impacting their desire to stay on the unit hired. The Transition Shock theory supports the uncertainties NLRNs experience in communicating, connecting, and dealing with the unrealistic expectations of colleagues.[2] Findings from a 2020 study described the impact that supportive colleagues have on a NLRN feeling comfortable to ask questions. One participant from that study noted that "they [colleagues] always have my back"[1](p.72). This dissertation project adds to the above study by providing additional supportive quotes and themes. It extrapolates colleagues' attributes that significantly influence the NLRN's transition to practice experience.

NLRNs in this study described both positive and negative attributes in their colleagues that impacted the transition experience. A few NLRNs described in detail instances of "bullying" or "nurses eat their young" by their colleagues, which directly impacted the NLRNs desire to stay on their unit. Thus, while it is expected that NLRNs will encounter a variety of attributes in their colleagues, it should not be expected that a culture of "bullying" or "nurses eat their young" is accepted. Therefore, NRP leadership and unit managers must prioritize cultures of support, acceptance, and safety in NRPs.

Finally, several participants in this study referred to the people they encountered "like a family," described the director and unit leader "like a mom," "maternal," or the bonding that occurred with colleagues and peers "like a family." Tidwell (2012) described what the NLRNs in this study describe in a family metaphor when she states

> "new nurses start to feel at home and committed to stay in an organization when they are empowered in practice, have a sense of belonging in a work group, and perceive that resources balance job stress"[85](pg. 5).

Thus, the NLRNs desire for acceptance and belonging "like a family" ultimately influences the transition to practice experience and solidifies the need for ongoing support and relationship development from each individual they encounter.

Summary of Themes: Activities Associated with NRP

The NLRNs in this study indicated how activities in the NRP influenced their transition to practice. The timing, presentation style, and topics of the NRP had the most significant influence on NLRNs. Each is described below.

First, the activities' timing greatly influenced how the NLRN acquired knowledge, gained confidence, and socialized in their first year. For example, some of the NLRNs described how skills training early in the NRP enhanced their confidence moving forward. This notion is supported by the Novice to Expert Model that, as an advanced beginner the NLRN seeks to remember tasks.[86] Next, once the NLRN attains increased confidence in skills, they want to practice skills as an advanced beginner. Findings from the qualitative study support this attribute of confidence and closely aligns with the Novice to Expert Model. NLRNs described the attributes of engaging activities such as case study, simulation, and hands-on clinical experiences had on positively influencing the NRP.

Next, in this study, NLRNs reported that the timing of activities impacted the experience. Activities included group discussions with peers, interactions with guest speakers, and interprofessional shadow experiences. The timing had either a positive or negative impact as it allowed for opportunities for role socialization. For example, those NLRNs who had the opportunity to experience group discussions with peers periodically throughout the NRP expressed a positive impact on their confidence and minimizing feelings of loneliness and fear. As described previously, the NLRN is positively influenced during the transition to practice when they feel "like a family," and the timing of some activities supports this by allowing for time to establish this type of rapport. For example, activities like group discussion, simulation, and shadow experiences enhance relationship development and role socialization and should be prioritized.

NLRNs from this study described how classroom sessions' attributes, such as guest speakers or content, had a positive or negative impact on the NLRNs ability to acquire, retain, and use new knowledge. For example, participants described that when an educator was stimulating and interactive in their presentation style, the NLRN felt engaged and interested. But when the educator passively provided information or did not engage verbally or non-verbally, then the NLRN felt disengaged and didn't remember the content. Many participants from this study indicated that the NRP activities felt like "nursing school" because of long, passive PowerPoint presentations. Therefore, those developing NRP educational content and guest speakers need to be selective in the educator's teaching ability to ensure they are engaging, using more concept-based learning, and providing interactive and interpersonal presentations. Also, evaluation

measures to assess learner, topic, and educator outcomes before and after the classroom sessions are warranted.

NLRNs in this study described how the content in the classroom session and activities positively and negatively influenced their transition to practice. For example, NLRNs indicated that NRP activities or classroom sessions that involved interprofessional educators or activities influenced the transition to practice experience. Learning about the roles of and from interprofessional colleagues increased the opportunity for NLRNs to practice enhanced communication skills, experience how to better coordinate patient care, and learn the value of teamwork. Findings from this study and previous studies support the challenges NLRNs experience with communication in the first year of practice.[1,3,28] NLRNs are expected to have extensive interpersonal communication and relational interactions with physicians, allied healthcare providers, patients, and families, which is not a skill that is always learned during nursing school. These skills build confidence and experience. Thus, NLRNs should be exposed to activities in the NRP that supports interpersonal communication and coordination of patient care from interprofessional educators. Also, the accrediting body of Graduate Medical Education prioritizes medical residents' needs to demonstrate competence in interpersonal and communication skills with health professionals.[66] Nurses and physicians work extensively together to provide patient care. Like Graduate Medical Education, NRPs need to prioritize opportunities for enhanced communication with interprofessional team members.

Finally, NLRNs in this study wanted to learn about the roles and from people they would be working with, like physicians, social workers, pharmacists, and physical

therapists. The participants also wanted the people like guest speakers who were teaching during the NRP to provide practical examples to help them apply new knowledge for practice. When the NLRNs felt that the topics applied to their growth and development over the first year of practice, they were more eager to learn and engage. On the other hand, if the topics didn't apply to the clinical setting or the guest speaker did not provide practical examples to practice, the NLRN reported boredom, zoning out, and disengaging from the experience. In some instances, NLNRs reported the classroom sessions to be a waste of time. Therefore, the guest speakers need to espouse expertise and include content that provides practical relevance based on the needs of the NLRNs during NRP class sessions and activities.

Some NLRNs in this study identified the positive impact that mentoring and shadow experiences had on their transition to practice, which is also supported in previous literature.[3,42,48] Yet, mentoring activities were underrepresented by the NRPs in this study. Mentoring and shadowing activities enhance opportunities for support, role socialization, interprofessional interactions, and communication and should be integrated into programs.

Mentoring and clinical rotations are a requirement of Graduate Medical Education. Researchers assert that the mentoring relationships in Graduate Medical Education are a win-win for the academic and professional advancement of both mentor and mentee.[87] Likewise, clinical rotations are a core aspect of Graduate Medical Education.[66] The NLRNs in this study reported the positive influence that shadow experiences and mentoring had, and thus both warrant further consideration and research for NRPs.

Finally, the impact that evidence-based practice projects being conducted within a healthcare unit had on NLRNs in this study was inconsistent. Previous studies have described positive outcomes associated with the use of EBP projects by the chief nursing officer, NRP coordinators, and nursing managers[14] but did not examine from the perspective of the NLRN. In this study, some NLRNs reported positive influences from the project, like gaining knowledge, feeling like they were contributing to their clinical unit, or experienced bonding with colleagues and peers. Other participants described the project as having a negative influence like not feeling equipped to execute the project due to lack of knowledge, inability to get staff buy-in, or added stress.

The ACGME accreditation standards requires medical residents to participate in scholarship that meets the needs of the healthcare organization and "will reflect its mission(s) and aims, and the needs of the community it serves"[66] (pg. 31). Like medicine, nursing is an art and a science, and the use of evidence and scholarship supports the advancement of nursing. The requirement of scholarship for NLRNs through an evidence-based practice project in the first year of practice needs further consideration and research to support the continued use in NRPs.

Summary of Themes: Structural Elements Associated with NRP

The NLRNs in this study indicated how the structure of the NRP influenced them in positive or negative ways. The participants indicated that the overall structure of the NRP needed to be convenient and conducive to learning. This outcome included the length and timing of meetings, the preceptorship experiences and the structure coinciding with the learning and socialization needs of the NLRN. Each of these attributes will be described in detail below.

The timing of the NRP meetings had a resounding negative impact on the NLRNs experience. For example, many participants described instances where the NRP meetings were inconveniently scheduled following night shift or on their days off. The result was that the NLRN experienced additional stressors from the demands of scheduling around NRP meetings, coming in on days off, or staying over after a twelve-hour night shift. This outcome negatively impacted the transition to practice experience. Therefore, NRP directors and unit leaders need to schedule protected time for NLRNs to participate in meetings.

Next, NLRNs described how the timing and sequence of meetings influenced their potential to gain new knowledge during the first year of practice. Supported by the Theory of Transition Shock, the NLRNs in this study described feelings of anxiety in the first few months of practice because they felt incompetent, lacked knowledge, and confidence.[2] The NLRNs in this study that experienced NRP structures that encouraged bonding with cohort peers, skills practice, and integrated new knowledge during the first few months reported feelings of increased confidence. In several instances, NLRNs reported that within six months of starting the program they needed a more engaging and stimulating NRP structure. NLRNs indicated that they needed different content in the second half of the NRP to focus on enhancing relationships and professional development beyond the first year and is supported in prior studies.[36] When the sequencing and structure of the NRP were not conducive to growth and development over the first year, the NLRN reported feeling disengaged, bored, fearful, or incompetent. Thus, NRP directors should carefully develop the program's structure and content based on the needs of the NLRNs.

Finally, preceptorships are an integral attribute to the first year of practice for any NLRN. In this study, only nine participants indicated that the preceptorship was considered a component of the NRP. The NLRN had a preceptorship, but the experience was understood by the participant to be a separate component to the NRP. For those participants, the preceptorship attributes were not discussed, as the aims of this study sought only to understand the attributes of NRPs that influence the NLRN.

The use of a preceptorship component in NRPs to enhance the transition to practice is evident in previous literature. The benefit of the preceptorship is apparent when the structural elements like length, number of preceptors, preceptor training, and unit selection meet the needs of the NLRNs. Several attributes of a negative preceptorship experience were reported in this study including insufficient preceptorship hours, intense clinical expectations, too many preceptors, and a lack of trained preceptors.

The dissertation findings and the previous literature suggest that fewer trained preceptors assigned to one NLRN are beneficial to the overall experience. For example, one study described dissatisfaction among NLRNs participating in an NRP that used multiple preceptors. The challenges described by the authors related to inconsistency in preceptors creating challenges with developing meaningful relationships.[39] Also, in a 2020 study, NLRNs expressed feelings of support and confidence when having only one preceptor.[1] Both of these findings were supported by the findings in this dissertation study.

The structural elements of the preceptorship experience in NRPs remain essential yet inconsistent in attributes such as length of the preceptorship and preceptor training. Several NLRNs from this study reported high levels of stress and anxiety related to the

preceptorship experience. The length of the preceptorship and the lack of preceptor training were contributing factors to these feelings.

Compared to other allied health profession models, medical residencies use a similar model for clinical immersion in Graduate Medical Education, but the programs are cohesive and consistent for all medical residents. The ACGME outlines the faculty's role as a foundational aspect of Graduate Medical Education as faculty teach residents how to care for patients and requires faculty to be qualified and express a desire to teach and participate in regular faculty development. Also, the ACGME outlines the structural components like curriculum and evaluation for all residencies.[66] The CCNE accreditation body for NRPs also requires the appropriate training for preceptors and sets forth the need for NRPs to provide preceptorship experiences in a structured and logical manner.[88] Thus, like medical residencies, the preceptorship experience should be consistent, and evaluation should be used to determine NLRNs readiness for practice. Also, to promote the standardization and quality of the experience, preceptors should receive training, yearly professional development, and regular evaluations.

Finally, preceptorships should be considered a structural element of all NRPs and fully integrated across the program. This conclusion is also supported in a large longitudinal, multi-site control group study from 2015 on NLRN transition to practice.[15] In doing so, NRP structures become more cohesive experiences, and the people involved are communicating; the activities are strategically placed and intersect at time points that positively influence the NLRNs' first year of practice.

Limitations

The limitations of this study are outlined below. First, purposive sampling strategies were used to identify participants from the different NRP models across the US, including the evidence-based models (EBM) like Vizient/AACN and Versant NGNR and facility-based models (FBM) from individual healthcare systems. Also, identifying participants from NRPs within ANCC Magnet Designated healthcare systems was noted. As seen in the Chapter 4 study design results, 75% (n=15) of the participants completed a FBM, and only 25% (n=5) completed an EBM with only one of those being the Versant NGNR. While the authors identified types of NRPs, the imbalance in participants from EBMs limited the ability to use this data within the study design.

The recruitment of individuals from the Versant NGR was challenging which created a limitation on how these programs' attributes influence NLRNs. Also, there were no participants included in this sample from state coalition NRPs which limits any understanding of how these models are influencing NLRNs.

Next, the sample from the dissertation study was not diverse. A low percentage 10% (n=2) of males was included in the sample and limited an understanding and generalizability of how the attributes of NRPs are influencing specific genders. Also, only a few racial groups were represented other than white, with 10% (n=2) Black/African American and 10% (n=2) Asian/Asian American. Thus, generalizability to racial groups is limited. Seventy percent (n=14) of the participants in the study had a bachelor's degree in nursing, which is a requirement of some EBMs. Still many NLRNs continue to enter the practice setting with an associate degree. Based on an imbalance in

educational levels of participants, the generalizability of the attributes of NRPs influencing NLRNs based on the level of education was limited.

Finally, this study included only NLNRs participating in NRPs within the hospital setting who were willing to talk about their experiences. Thus, a limitation of this study is understanding how NRPs outside of the hospital influence NLRNs.

Future Research

There are several areas for future research to enhance the practice experience for NLRNs. First, research designs should include more diverse samples including race, gender, and educational level to better represent the nurse population. Diversifying study samples will help understand NRPs from various perspectives to meet the needs of all NLRNs entering the profession.

The next research area should focus on taking the findings from this study and developing and testing an instrument to evaluate the attributes of NRPs. The components and attributes reported by NLRNs, including the people, activities, and structure of the NRP, will be included in the instrument with Likert Scales to evaluate each component. The author's goal is to complete a pilot study of this type of instrument and revise as needed and then complete a larger scale study to determine instrument reliability.

Additional research is needed to elaborate on the findings from this study by recruiting ten additional participants using purposive sampling to focus on recruitment from the accredited EBM NRPs with Magnet designated healthcare systems. The data can be added to this study and reanalyzed with a lens of comparing the attributes from the different NRP models, EBM, FBM, and state coalitions from Magnet versus non-Magnet designated health care systems.

Next, given the impact of the Covid-19 pandemic on the healthcare system, the impact on NLRNs and implementation of NRPs, a study is needed to understand the needs of NLRNs entering practice. The goal should be to inform nursing education and NRPs on the needs of NLRNs transitioning to practice during an pandemic.[89]

Lastly, more long-term research is needed to examine programs over time to identify how standardized and accredited NRPs directly impact patient satisfaction and outcomes, thus improving the overall healthcare system.

Practical Implications

The practical implications of this study are outlined in this section from an educational, practice, and policy perspective and described in detail below.

First, this study lends further support for the needs of NLRNs entering practice. The goal of NRPs is to support a more seamless transition to practice period to enhance skills, knowledge, competence, and role socialization for NLRNs. Yet findings reveal that not all NLRNs have positive experiences. While the goal of an NRP is to minimize the challenges NLRNs experience because of the preparation-practice gap, the reality is a chasm still exists. Therefore, all NRPs should be designed with a practice partnership collaborative between a school of nursing and healthcare institution. This collaborative supports the Novice to Expert Model, further enhancing the growth and development of nurses over time. Thus, NLRNs entering practice will receive support through a collaborative between nurse educators and leaders across institutions strengthening communication lines, and creating a conduit to minimize the preparation-practice gap.

A practice partnership collaborative supports a pipeline of NLRNs into the health care system and potentially could impact retention rates with enhanced professional

development, certifications, or advanced education opportunities. The need for the practice partnership is supported by the American Academy of Nursing policy recommendation number three that states:

> "NRPs will be designed, established, and administered in collaboration with an academic school or college of nursing and the hospital, since NRPs are considered postgraduate education after conferring the ADN or BSN degree"[77] (pg. 331).

NLRNs need immense support from everyone they encounter throughout the first year of practice. As outlined in this dissertation study, it is essential key individuals must be identified by NRP leadership based on their attributes and trained on the interpersonal, relational, educational, and communication needs of NLRNs. To accomplish this need, NRPs need to have highly qualified directors overseeing the development of programs and adequate numbers of educators, preceptors, and mentors to meet the needs of the NLRN. Also, the ACGME considers the need for highly qualified directors a standard for the accreditation of graduate medical education programs.[66]

For decades the profession of nursing has used a preceptorship orientation model to support nurses' transitioning from nursing education to practice. However, as healthcare complexities have increased over the last twenty years, this model alone has become inadequate. Thus, over the last 20 years, nursing advocacy organizations and researchers have asserted the need for an enhanced transition to practice through NRPs. While NRPs have evolved some since these national calls to action, the variability among NRP components and attributes is evident. Yet, the state of the science and the findings in this dissertation project support positive outcomes of increased competence, confidence, and retention rates. Thus, NRPs have the most significant potential for improving the transition to practice experience for NLRNs. But, just like schools of

nursing and Graduate Medical Education, NRPs should be standardized across all health care settings, so all NLRNs entering practice are afforded the same transition experience.

To strengthen the nursing workforce, NLRNs need a standardized and protected period to enhance competence, gain confidence, and socialize into the profession. This period needs to include immersive clinical and didactic learning experiences taught by dedicated and trained professionals. Continuing to implement NRPs without standardization of programs will create fragmentation and suboptimal outcomes or negative consequences for nurses, the largest care provider in the US. Physicians are not required to go directly into practice without a highly supportive and dedicated transition period, and neither should nurses. Thus, researchers, educators, healthcare leaders and policy makers need to advocate for the standardization of NRPs and for state boards of nursing to require all NLRNs to complete a one-year accredited NRP.

Many healthcare organizations have been reluctant to implement NRPs. Evidence suggests this may be related to the high cost of implementation.[90] Therefore, just like Graduate Medical Education is primarily funded through federal dollars, policymakers need to allocate funding to support NRPs. Title VIII Nursing Workforce Reauthorization Act of 2019 allocates funding for the nursing workforce through the fiscal year 2024.[91] Federal policymakers need to prioritize the needs of NLRNs entering the profession, especially given the issuing of temporary practice license for newly graduated nurses during the COVID-19 pandemic.[89] Health care organizations may not have the resources to implement, standardize, or accredit NRPs without proper funding from the federal government and nursing stakeholders. However, never has the essential care that nurses

provide been more apparent than it is today in the US; thus the future of our healthcare system relies on the proper transition to practice for every nurse.

Conclusion

This dissertation project is a culmination of evidence from within the literature and data analyzed directly from NLRNs participating in NRPs in the US. Each chapter expands on the potential and shortcomings of NRPs as they exist today. The common thread among each chapter in this dissertation project supports the ways NRPs can improve competence, confidence, and socialization in NLRNs transitioning to practice. Yet, a gap existed on how NRPs influenced the NLRN transition to practice. Through a qualitative description study design and interviewing NLRNs in various programs, the attributes that most impact NLRNs were revealed. This dissertation project advances the state of the science from the perspective of NLRNs participating in a variety of NRPs. This study named a variety of influential attributes and substantiated how NRPs can strengthen the NLRN workforce by standardizing all NRPs. Finally, the most critical implication for NRP leaders is if an NRP lacks ubiquitous support, then the program will not meet the needs of NLRNs transitioning to practice.

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CURRICULUM VITAE

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Education

Doctor of Philosophy — December 2020
Indiana University, Indianapolis, IN
Major: Nursing
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Master of Science in Nursing — December 2009
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Certifications

RN License- IN — October 2019

Professional Experience

Indiana University School of Nursing-Teaching Assistant 2019
Marian University School of Nursing- Assistant Professor of Nursing 2010-2017
Marian University School of Nursing- Adjunct Faculty 2010-2010
Clinical Faculty Leadership and Management and Pediatrics- 2007-2010
Riley Hospital for Children-Registered Nurse General Medical/Surgical
Academy Allergy Asthma & Sinus Registered Nurse 2007-2010
St. Mary's Hospital-Registered Nurse Adult Medical/Surgical 1999-2001

Awards and Recognition

Robert Wood Johnson Foundation Future of Nursing Scholar 2017-2020
Indiana University School of Nursing Health Policy Eagle Award 2019
AACN-GNSA Emerging Leader Recognition Spring 2019
Sigma Nursing Aspiring Member Recognition Summer 2018
Emily Holmquist Award Indiana University School of Nursing 2018
Nursing Education Scholarship Indiana University School of Nursing 2008
Margaret Martin Award Excellence in Pediatric Nursing Nominee 2005, 2007
Riley Hospital for Children
Academic Honors Award Recipient-University of Southern Indiana 1996-2000

Professional Organizations

Indiana State Nurses Association 2001-present
American Nurses Association 2001-present
Sigma Theta Tau International Honor Society of Nursing 2011-present

Omega Chapter Vice President	2014-2016
Region 9 Committee Member	2016-2017
President Alpha Chapter	2016-2018
Leadership Succession Committee	2019-present
American Association of Colleges of Nursing	2019-present
Academy Health National Chapter	2018-present
Academy Health IUPUI Student Chapter	2018-present
Society of Nurse Scientist Innovators Entrepreneurs and Leaders SONSIEL	2019-present

Academic Committees

Marian University 2010-2016

1. Student Nurses Association Faculty Advisor (2010)
2. Curriculum Committee member and chair (2011-2014)
3. Faculty Council Secretary (2013-2015)
4. Progression & Outcomes Committee (2014)
5. Timmy Global Health Nursing Faculty Advisor (2014)
6. Elections Committee (2016)

Indiana University School of Nursing 2017-2020
PhD Committee Student Representative

Professional Development

Creative Teaching Strategies for the Nurse Educator	2011
NLN Scholarly Writing workshop Publish Don't Perish	2012-2013
Pursuing Radical Transformation in Nursing Education	2012
Global Missions Health Conference	2013,201
Sigma Theta Tau International Biennial Convention Delegate	2015, 2017
Distinguished Lectureship Cultivating Healthy Populations, Inspiring a Collective Vision	2016
Innovations in Faith Based Nursing	2016
AFCU Conference	2016
Global Leadership Summit	2016
NLN Education Summit	2016
Indiana Nursing Summit	2016
Robert Wood Johnson Foundation Future of Nursing Scholars Annual Conference	2017, 2018, 2019

Presentations

1. Kiger, C. & Freeland, J. The Integration and Utilization of Franciscan Values Throughout the Curriculum for the Development of Aspiring Health Care Leaders. Podium Presentation AFCU Conference Marian University (2016)
2. Kiger, C. & McNelis, S. Implementing High Fidelity Simulation Experiences Using Live Streaming Technology into the Classroom Environment to Enhance

Student Education. Poster Presentation National League for Nursing Education Summit (2016)
3. Kiger, C. An Innovative Practice Partnership for the Advancement of the BSN Pipeline Initiative. Poster Presentation Sigma Theta Tau International Biennial Convention (2017)
4. Kiger, C. The Impact of Interpersonal Attributes and Communication Styles in the Nurse Residency Preceptorship. Podium Presentation Robert Wood Johnson Foundation Future of Nursing Scholars Annual Conference (2018)
5. Kiger, C. Nurse Residency Programs. Podium Presentation Robert Wood Johnson Foundation Future of Nursing Scholars Annual Conference (2019)
6. Kiger, C. Interpersonal Communication Competence and Attachment Styles in Pre-licensure Nurses: A Descriptive Pilot Study. Indiana University School of Nursing Rising Star of Research & Scholarship Sigma Theta Tau International Biennial Convention Poster Presentation (2019)
7. Kiger, C. Nurse Residency Programs: A Concept. Analysis Sigma Theta Tau International Biennial Convention Podium Presentation (2019)

Professional Activities and Continuing Education

1. Haiti Medical Mission Trip (2010, 2014)
2. Robert Wood Johnson Foundation Webinar Series
   Ask the Expert-Mentorship (2017)
   Responsible Conduct of Research (2018)
   Ask a Mentor (2018)
   Funding for Science (2018)
   Ask a Community Based Researcher (2018)
   Funding for Science (2018)
   Entering the Conversation (2018)
   Data Analysis (2018)
   Ask A CNO (2018)
   Tips on Publishing (2019)
   Ask a Dean (2019)
   Ask a Post Doc (2019)
   Science and Policy (2019)
   Post Doc Opportunities (2019)
3. Indiana University School of Nursing Health Policy Intensive & Indiana State House Visit (2019)

Research Projects

1. Master's Thesis Project Are We In Need of a Change in Clinical Education? The Dedicated Education Unit (2009)
2. Interpersonal Communication Competence and Adult Attachment Styles in Prelicensure Nurses: A Descriptive Pilot Study (2018)
3. Nurse Residency Programs: A Concept Analysis (2018)
4. Current Trends in Nurse Residency Program Structures & Outcomes: An Integrative Review (2019)
5. The Attributes of Nurse Residency Programs Influencing the Newly Licensed Registered Nurse (2019-2020)